New York City Comptroller
Scott M. Stringer

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007

Form Version: NYC-COMPT-BLA-PD1-D2

Property Damage or Loss Claim Form

Electronically filed claims must be filed within 90 days of the occurrence using the Office of the NYC Comptroller's website. If the claim is not resolved within one (1) year and 90 days of the occurrence, you must start a separate legal action in a court of law before the expiration of this time period to preserve your rights.

I am filing: ◯ On behalf of myself.

◯ On behalf of someone else. If on someone else's behalf, please provide the following information.

Last Name:	
First Name:	
Relationship to the claimant:	

Claimant Information

*Last Name:	
*First Name:	
*Address:	
Address 2:	
*City:	
*State:	NEW YORK
*Zip Code:	
*Country:	USA
Date of Birth:	*Format: MM/DD/YYYY*
Soc. Sec. #	
HICN: (Medicare #)	
Date of Death:	*Format: MM/DD/YYYY*
Phone:	
*Email Address:	
*Retype Email Address:	
Occupation:	

City Employee? ◯ Yes ◯ No ◯ NA

Gender ◯ Male ◯ Female ◯ Other

◯ Attorney is filing.

Attorney Information (If claimant is represented by attorney)

Firm or Last Name:	
Firm or First Name:	
Address:	
Address 2:	
City:	
State:	
Zip Code:	
Tax ID:	
Phone #:	
*Email Address:	
*Retype Email Address:	

The time and place where the claim arose

*Date of Incident:	*Format: MM/DD/YYYY*
Time of Incident:	*Format: HH:MM AM/PM*
*Location of Incident:	
Address:	
Address 2:	
City:	
*State:	NEW YORK
Borough:	

Property Clerk Voucher Number:	
District Attorney Release Number:	

**** Denotes required fields.***
A Claimant OR an Attorney Email Address is required.

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***Manner in which claim arose:**

**** Denotes required field.***

The items of damage claimed are (include dollar amounts):

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Witness 1 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone #:

Witness 2 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone #:

Witness 3 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone #:

Witness 4 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone #:

Witness 5 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone #:

Witness 6 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone #:

Police Information

Police Officer Last Name:	
Police Officer First Name:	
Shield Number:	
Precinct:	
Report Number:	

Please indicate which of the following reports you have

- ☐ Accident Report
- ☐ Aided Report
- ☐ Complaint Report

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Insurance Information

Do you have insurance?	◯ Yes	◯ No
Did you report your accident to your insurance company?	◯ Yes	◯ No
Were you paid by your insurance company?	◯ Yes	◯ No
Is payment pending?	◯ Yes	◯ No

Deductible Amount:	
Insurance Company Name:	
Address:	
Address 2:	
City:	
State:	
Zip Code:	
Policy #:	
Phone #:	
Agent Name:	

City vehicle information

Plate #:	
City Driver Last Name:	
City Driver First Name:	
Total Amount Claimed:	

*The **Total Amount Claimed** can only be entered once the following required fields are entered:*

Format: Do not include "$" or ",".

Claimant Last Name
Claimant First Name
Claimant Address, City, State, Zip code, Country
Claimant Email or Attorney Email
Date of Incident
Location of Incident
Manner in which claim arose

I certify that all information contained in this notice is true and correct to the best of my knowledge and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties and civil liabilities.