



# 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:

\*Zip Code:

\*Country:

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:

Borough:

Property Clerk Voucher Number:

District Attorney Release Number:

**\* Denotes required fields.**  
**+Denotes field that is required if attorney is filing.**  
**A Claimant OR an Attorney Email Address is required.**



New York City Comptroller  
Brad Lander

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

**\*Manner in which  
claim arose:**

A large, empty rectangular box intended for the user to provide details on the manner in which a claim arose.

**\* Denotes required field.**

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



**Witness 1 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 2 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 3 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:**

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

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

- 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*
- Attorney Last Name, First Name, Address, City, State, Zip Code, and Email if attorney is filing.*

*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.*