New York City Comptroller
Brad Lander

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

Form Version: NYC-COMPT-BLA-PI1-E

Personal Injury 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:	

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

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***Manner in which claim arose:**

**** Denotes required field.***

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

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Medical Information

1st Treatment Date: *Format: MM/DD/YYYY*
Hospital/Name:
Address:
Address 2:
City:
State:
Zip Code:
Date Treated in Emergency Room: *Format: MM/DD/YYYY*
Was claimant taken to hospital by an ambulance? ◯ Yes ◯ No ◯ NA

Employment Information (If claiming lost wages)

Employer's Name:
Address
Address 2:
City:
State:
Zip Code:
Work Days Lost:
Amount Earned Weekly:

Treating Physician Information

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

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:

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Complete if claim involves a NYC vehicle

Owner of vehicle claimant was traveling in

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

Non-City vehicle driver

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

Insurance Information

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

Non-City vehicle information

Make, Model, Year of Vehicle:
Plate #:
VIN #:

City vehicle information

Plate #:

City Driver Last Name:
City Driver First Name:

Description of claimant:

- ◯ Driver
- ◯ Passenger
- ◯ Pedestrian
- ◯ Bicyclist
- ◯ Motorcyclist
- ◯ Other

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, and Country
Claimant Email or Attorney Email
Date of Incident
Location of Incident (including State)
Manner in which claim arose

If attorney is filing, the following fields are also required:
Attorney Last Name, First Name, Address, City, State, Zip Code, Email

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.