



Personal Injury Claim Form

Electronically filed claims must be filed at the NYC Comptroller's Website. If your claim is not resolved within 1 year and 90 days from the date of occurrence you must start legal action 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:

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



New York City Comptroller
John C. Liu

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 the claim arose.

*** Denotes required field.**



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



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:

Witness 2 Information

Last Name:

First Name:

Address:

Address 2:

City:

State:

Zip Code:

Witness 3 Information

Last Name:

First Name:

Address:

Address 2:

City:

State:

Zip Code:

Witness 4 Information

Last Name:

First Name:

Address:

Address 2:

City:

State:

Zip Code:



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 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.