

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

Form Version: NYC-COMPT-BLA-PI1-D6

Personal Injury Claim Form

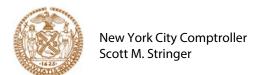
Electronically filed claims must be filed within 90 days of the occurrence using the Office of the NYC Comptroller's website. If the claim is not resolved within one (1) year and 90 days of the occurrence, you must start a separate legal action in a court of law before the expiration of this time period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

I am filing: On behalf of myself. On behalf of someone else. If on someone else's	Attorney is filing.Attorney Information (If claimant is represented by attorney)		
behalf, please provide the following information.			
Last Name:	Firm or Last Name:		
First Name:	Firm or First Name:		
Relationship to	Address:		
the claimant:	Address 2:		
	City:		
Claimant Information	State:		
*Last Name:	Zip Code:		
*First Name:	Tax ID:		
*Address:	Phone #:		
Address 2:	*Email Address:		
*City:	*Retype Email Address:		
*State:	The time and place whe	ere the claim arose	
*Zip Code:	*Date of Incident:	Format: MM/DD/YYYY	
*Country:	Time of Incident:	Format: HH:MM AM/PM	
Date of Birth: Format: MM/DD/YYYY	*Location of	Tomac. The Nill All All All All All All All All All	
Soc. Sec. #	Incident:		
HICN: (Medicare #)			
Date of Death: Format: MM/DD/YYYY			
Phone:			
*Email Address:			
*Retype Email Address:			
Occupation:			
City Employee? Yes No NA			
Gender			
	Address:		
	Address 2:		
	City:		
	*State:		
	Borough:		

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



411(13)	
*Manner in which	
ala tana ana ana	
claim arose:	



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



Medical Information		Witness 1 Information		
1st Treatment Date:	Format: MM/DD/YYYY	Last Name:		
Hospital/Name:		First Name:		
Address:		Address		
Address 2:		Address 2:		
City:		City:		
State:		State:		
Zip Code:		Zip Code:	Phone:	
Date Treated in Emergency Room:	Format: MM/DD/YYYY	Witness 2 Information		
Was claimant taken to hos an ambulance?	pital by Yes No NA	Last Name:		
		First Name:		
Employment Informatio	n (If claiming lost wages)	Address		
Employer's Name:		Address 2:		
Address		City:		
Address 2:		State:		
City:		Zip Code:	Phone:	
State:		Witness 3 Informati	on	
Zip Code:		Last Name:		
Work Days Lost:		First Name:		
Amount Earned Weekly:		Address		
Treating Physician Information		Address 2:		
Last Name:		City:		
First Name:		State:		
Address:		Zip Code:	Phone:	
Address 2:		Witness 4 Informati	on	
City:		Last Name:		
State:		First Name:		
Zip Code:		Address		
	_	Address 2:		
		City:		
		State:		
		Zip Code:	Phone:	



Complete if claim involves a NYC vehicle

Owner of vehicle claimant was traveling in		Non-City vehicle di	Non-City vehicle driver		
Last Name:			Last Name:		
First Name:			First Name:		
Address			Address		
Address 2:			Address 2:		
City:			City:		
State:			State:		
Zip Code:			Zip Code:		
Insurance Informat	ion		Non-City vehicle in	formation	
Insurance Company Name:			Make, Model, Year of Vehicle:		
Address			Plate #:		
Address 2:			VIN #:		
City:			City vehicle information		
State:			Plate #:		
Zip Code:			Plate #:		
Policy #:					
Phone #:			City Driver Last Name:		
Description of claimant:	Oriver	○ Passenger	City Driver First		
	Pedestrian	Bicyclist	Name:		
	Motorcyclist	Other			
Total Amount Claimed:			Format: Do not include "\$" or ",".		
The Total Amount C		e entered once the follow	wing		

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