



Property Damage or Loss Claim Form

Claim must be filed *in person or by registered or certified mail within 90 days of the occurrence* at the NYC Comptroller's Office, 1 Centre Street, Room 1225, New York, New York 10007. It must be *notarized*. If claim is not resolved within *1 year and 90 days of the occurrence*, you must start legal action to preserve your rights.

TYPE OR PRINT

- 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:

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:



The time and place where the claim arose

*Date of Incident: *Format: MM/DD/YYYY*
Time of Incident: *Format: HH:MM AM/PM*

Property Clerk
Voucher Number:
District Attorney
Release Number:

*Location of Incident:

Address:
Address 2:
City:
State:
Borough:

***Manner in which claim arose:**

Attach extra sheet(s) if more room is needed.

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

Attach extra sheet(s) if more room is needed.



Witness 1 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:	

Witness 2 Information

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

Witness 5 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 6 Information

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

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



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 ",".

Date

Signature of Claimant

State of New York
County of _____

I, _____, being duly sworn depose and say that I have read the foregoing NOTICE OF CLAIM and know the contents thereof: that same is true to the best of my own knowledge, except as to the matter here stated to be alleged upon information and belief, and as to those matters. I believe them to be true.

Sworn before me this day _____

Signature of Claimant _____

Signature of notary _____