



Property Damage or Loss 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:

Property Clerk Voucher Number:

District Attorney Release Number:

*** 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.**

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



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:

*The **Total Amount Claimed** can only be entered once the following required fields are entered: Format: Do not include "\$" or ",".*

- 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.