

NOTICE OF INTENTION TO MAKE CLAIM

THESE FORMS MUST BE SUBSCRIBED AND SWORN TO AND RETURNED TO US IN TRIPLICATE
PLEASE PRINT OR TYPE

TO:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

STATE OF NEW YORK

COUNTY OF _____

} SS.

_____, being duly sworn deposes and says:

My name is _____

Birth date of injured person _____

and I reside at _____

and vote in _____

County, New York,

and am employed by _____

Social Security No. _____

Pursuant to Article 52 and/or the pertinent Section of Article 18 of the Insurance Law of the State of New York, this affidavit is presented to for the purpose of giving my Notice of Intention to Make Claim against said carrier for damages sustained by me, attributable to the accident described below.

1. Date of Accident _____ (month, day, year) _____ (time)

2. Place of Accident _____ (street or highway) _____ (city or miles from city) _____ (state)

3. Vehicle No: 1 _____ (make) _____ (year) _____ (state) Vehicle No. 2 _____ (make) _____ (year) _____ (state)

REGISTRATION NO. _____

REGISTRATION NO. _____

Owned by: _____

Owned by: _____

Address: _____

Address: _____

Driven by: _____

Driven by _____

Address: _____

Address _____

Insured by: _____

Insured by: _____

Policy No. _____

Policy No. _____

Expiration date: _____

Expiration date: _____

4. (Attach additional sheet if more than two vehicles are involved.)

I was a driver

a passenger

of vehicle No. 1

I was pedestrian

of vehicle No. 2

5. Reported to police in _____

(state)

(precinct)

(date)

PLEASE FORWARD A COPY OF THE POLICE REPORT. ALSO A COPY OF CANCELLATION NOTICE

6. Description of injury and expense incurred. _____

7. Is your injury covered by insurance? Yes No
Are you receiving Worker's Compensation? Yes No

(name of company)

8. Description of Accident in Detail (Refer to Vehicles by Number 1, 2 or 3 _____

9. Does injured person(s) or member(s) of household own an automobile? Yes No
Owner's name _____
Name of Insurance Company _____
Policy No. _____ Injured Driver's License No. _____
Effective date _____ Expiration Date _____ Injured's registration No. _____

10. **WITNESS TO ACCIDENT (Important)**
1. _____ Address _____
(First Name) (Middle Name) (Last Name) (Street) (City) (State)
2. _____ Address _____
(First Name) (Middle Name) (Last Name) (Street) (City) (State)

11. Reason for application:
Uninsured Car Unidentified Car
Denial of Coverage or Uninsured Automobile Endorsement
Disclaimer on your policy.
Photostat copy of disclaimer letter must be attached. Qualified person
Stolen Car Underinsured Benefits

12. If more than 90 days have elapsed since accident occurred, advise the reason for the delay.

Sworn to before me this _____ day _____
of _____ 20__ _____

Notary Public (Sign here) Signature of person making claim

Give date report is made