

Notice of Intention to Make Claim

This form must be subscribed and sworn to. Fax or e-mail notification is not acceptable.

To: MOTOR VEHICLE ACCIDENT INDEMNIFICATION CORPORATION
100 WILLIAM ST, 14th Floor
NEW YORK, N.Y. 10038 phone: 646-205-7800

State of New York -
County of _____ -ss.

Pursuant to Article 52 and/or pertinent sections of Article 18 of the Insurance Law of the State of New York, this affidavit is presented to the Motor Vehicle Accident Indemnification Corporation for the purpose of giving my Notice of Intention to Make Claim against said Motor Vehicle Accident Corp. for injuries sustained by me. I have been duly sworn and state:

My name is _____; my date of birth is _____

I reside at _____;
Street Address /Apt City - State - Zipcode

My Social Security # is: _____ My email is: _____
My telephone number is: _____

I am employed by: _____ [] Unemployed

I was involved in an automobile accident on: _____
Month Day Year time (am/pm)

Place of Accident: _____
Street or highway City State

I was driver [] a passenger [] of vehicle #1 [] a pedestrian []
vehicle #2 [] a bicyclist []

Vehicle #1 _____ Vehicle #2 _____
Year/Make/Model/Color Year/Make/Model/Color

License Plate #: _____ State _____ License Plate #: _____ State _____

Owner: _____ Owner: _____
Address: _____ Address: _____

Driver: _____ Driver: _____
Address: _____ Address: _____

Insured by: _____ Insured by: _____
Policy #: _____ Policy #: _____
Effective Date: _____ Expiration date: _____ Effective Date: _____ Expiration date: _____

The accident was reported to the Police on _____, in _____
Date Precinct - City - State

Description of Injury & Expense Incurred: _____

Is your injury covered by insurance? Yes [] _____ No []
Name of Insurance Company

Are you receiving Worker's Compensation? Yes [] _____ No []
Name of Insurance Co.

Description of Accident

Did anyone live with you on the date of accident? Yes [] No []

If yes, list all the people that lived with you on the date of accident:

<i>Name</i>	<i>Relation</i>	<i>Date of Birth</i>	<i>Social Security Number</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do any of the people you live with own a vehicle: Yes [] No []
Owners name _____
Insurance Company _____
Policy #: _____ Effective: _____ Expires: _____

Witnesses to the Accident

Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Telephone: _____	Telephone: _____

Reason for application to Motor Vehicle Accident Indemnification Corporation:
Uninsured Car [] Stolen Car []
Denial of Coverage [] *attach copy* Unidentified Car []
Disclaimer of Coverage [] *attach copy*

>>>>>>>>> **Attach a copy of both sides of Police Report** <<<<<<<<<<<<<<<

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON WHO 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 ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH VIOLATION.

Sworn to before me this _____ day _____
Of _____, 20____ (Signature of person making claim)

Notary Public (signature)