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:

Name ***Relation*** ***Date of Birth*** ***Social Security Number***

_____
_____
_____
_____
_____

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)