


**Thruway
Authority**

Legal Department
P.O. Box 189
Albany, NY 12201-0189
Fax No. (518) 471-4340
Claimsunit@thruway.ny.gov

VEHICLE DAMAGE CLAIM FORM

Purpose: This form is used by patrons to file a claim for property damage incurred while traveling on the Thruway System.

CLAIMANT INSTRUCTIONS:

Complete all applicable Sections. Within 90 days of the incident, submit the completed form via mail, email or fax to the address/fax number above. The Legal Department will review your claim and respond in writing within approximately 8-10 weeks after the completed form is received. **Submitting this claim form does not guarantee payment or reimbursement.**

NOTE: This form is not a Notice of Intention to make a claim in the Court of Claims. You must pursue the remedies available under the Court of Claims Act. Under this Act there is a 90-day notice requirement, and the Thruway Authority (Authority) advises you to seek the assistance of an attorney for further information.

Section I Claimant Information

Vehicle Owner Name		Home Phone No. () -		Work Phone No. () -	
Address		City	State	Zip Code -	

Section II Vehicle Information

License Plate No.		State of Registration	Make	Model
Year	Odometer/Hours	Insurance Carrier		Policy No.
Have you filed a claim with your insurance carrier or received or expect to receive any payment from your insurance carrier for this claim? <input type="checkbox"/> Yes. If Yes, your claim must be submitted by the insurance company in accordance with its "Right of Subrogation." <input type="checkbox"/> No				

Section III Incident Information

Vehicle Operator Information (if other than owner)							
Operator Name		Operator Address				Operator Phone No. () -	
Incident Date	Incident Time	Town, City or Village	Direction of Travel	Lane of Travel	Nearest Exit	Thruway Milepost (if applicable)	
Roadway Incident Occurred On (i.e., number and/or name)						Did the incident occur in a construction zone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was an Authority vehicle involved? <input type="checkbox"/> No <input type="checkbox"/> Yes. If Yes, provide the following: Authority vehicle operator name: _____ License plate or equipment no.: _____						Total Cost of Repairs*	
Witness Name		Witness Address				Witness Phone No. () -	

Enter any police agencies notified of this incident

Description of Incident

Comments or any special circumstances you want to bring to our attention

Section IV Signature

_____	_____
Claimant Signature	Date

*** Attach paid bill or estimate(s) from an established business. If the claim is for replacement of a tire, the estimate(s) must contain a statement indicating the damaged tire could not be repaired and must reflect a deduction for depreciation.**