

INSTRUCTIONS:
Place only ONE letter or number in each space
and leave a blank space between words.

CIVIL COURT OF THE CITY OF NEW YORK
SMALL CLAIMS PART
STATEMENT OF CLAIM

(FOR OFFICE USE ONLY)

(Your)
I. CLAIMANT'S INFORMATION
LAST NAME **Wilson**
FIRST NAME **Beth** MIDDLE INITIAL **M.**
ADDRESS (NO P.O. BOX) **3256 Plaintiff Avenue**
BOROUGH, CITY, TOWN OR VILL. **New York** STATE **NY** ZIP **10113**
OTHER INFO
[Doing Business As] [In Care Of]
[Attention To] **Circle One** PHONE NO. **(212) 555-5555**

(Their)
II. DEFENDANT'S INFORMATION*
LAST NAME (or Full Business Name) **Continental Airlines, Inc., a Delaware Corporation** MIDDLE INITIAL
FIRST NAME
ADDRESS **111 Eighth Avenue**
BOROUGH CITY, TOWN OR VILL. **New York** STATE **N|Y** ZIP **10011**
OTHER INFO **c/o C T Corporation System**
[Doing Business As] [In Care Of]
[Attention To] **Circle One** PHONE NO. **(212) 319-9494**

III. CLAIM
Amount Claimed: \$ **3,000.00** (Maximum \$5,000) Date of Occurrence or Transaction: **Feb. 3, 2010**

Place of occurrence, if Auto Accident
PRIMARY REASON FOR CLAIM (Check One):

Damage caused to:	automobile	other personal property	real property	<input checked="" type="checkbox"/> person
Failure to provide:	proper repairs	proper services	proper merchandise	goods paid for
Failure to return:	security	property	deposit	money loaned
Failure to pay:	salary	for services rendered	insurance claim	
	rent	commissions	for goods sold and delivered	
Breach of:	<input checked="" type="checkbox"/> contract	lease	warranty	agreement
Loss of:	luggage	property	time from work	use of property
Returned:	check (bounced)	check (stopped)		
Other: (Be brief)				

IDENTIFYING NUMBER(S) - (Receipt #, Claim #, Account #, Policy #, Ticket #, License #, Plate #'(s)) **Ticket 1407951**

6/3/2010 Today's Date **Beth Wilson** Signature of Claimant or Agent

* DEFENDANT'S NAME: The legal name will be required in order to obtain an enforceable judgment. If the Defendant is a business, its full and correct Office of the County Clerk in the county in which the business is located or check on the following website: www.dcs.state.ny.us.
DEFENDANT'S ADDRESS: YOU must indicate the proper street address of the Defendant. A Post Office Box is not acceptable.

CIV-SC-50 (Revised 7/05)

NOTE: If the Claim is a result of an automobile accident, the Claim must be OWNER against OWNER.

CERT'D #

COA CODE

CLAIM AMT.

\$

FEE

STANDARD FEE

CLAIMANT V. DEFENDANT

NO FEE

DEFENDANT V. THIRD PARTY

CLAIMANT V. ADD'L DEFENDANT

POSTAGE ONLY

WAGE CLAIM TO \$300

LANGUAGE

DATE DATA ENTERED

DATE NOTICES MAILED

CASE TYPE:

MULTI DFT CTR/CLM

3 PARTY CRS/CMPLT

FIRST DATE

DAY COURT

STATUTORY OTHER

business name should be obtained from the