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)

I. CLAIMANT'S INFORMATION (Your)

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: Wilson's Delicacies

[Doing Business As] [In Care Of] [Attention To] Circle One — PHONE NO.: (212) 555-5555

II. DEFENDANT'S INFORMATION* (Their)

LAST NAME (or Full Business Name): Continental Airlines, Inc., a Delaware Corporation

FIRST NAME — MIDDLE INITIAL:

ADDRESS (NO P.O. BOX): 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	X 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:	X 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 **business name** should be obtained from the Office of the County Clerk in the county in which the business is located or check on the following website: www.dos.state.ny.us.
DEFENDANT'S ADDRESS: YOU must indicate the proper street address of the Defendant. A Post Office Box is not acceptable.

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

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