

# Attorney Questionnaire



*The Merit of Your Case is Your Strongest Asset*

(please type or print)

Date: \_\_\_\_\_

## CLIENT INFORMATION

Client's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Telephone (day): \_\_\_\_\_

Telephone (evening): \_\_\_\_\_

e-mail Address: \_\_\_\_\_

## ACCIDENT/INJURY INFORMATION

Date of accident/injury: \_\_\_\_\_

Defendant Ticketed? ..... yes ..... no (circle one)

Plaintiff ticketed? ..... yes ..... no (circle one)

Defendant DUI/DWI? ..... yes ..... no (circle one)

Plaintiff DUI/DWI? ..... yes ..... no (circle one)

Has Liability been established and/or admitted? ..... yes ..... no (circle one)

## TYPE OF CASE (check all that apply)

Traffic Accident

Medical Malpractice

Commercial Litigation

Dog Bite

Wrongful Termination

Wrongful Death

Product Liability

Sexual Harassment

Premises Liability

Discrimination

Nursing Home Neglect

Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Notice of Confidentiality

All information collected is for underwriting purposes only. All information shall be held in the strictest confidence and shall not be disclosed to anyone for any purpose unless instructed to by client, counsel or court order.

CASE DETAILS (provide a brief description of the facts)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Please note that we will not contact the defendant, defendant's Attorney, or Insurance Company. This information is for our records only)

**Name of Defendant:** \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Defendant's Attorney:** \_\_\_\_\_

Firm: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Plaintiff's Insurance Company:** \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Policy Limits: \_\_\_\_\_

Amount of Payments to Date: \_\_\_\_\_

**Claims Representative:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Defendants Insurance Company:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Limits: \_\_\_\_\_

Amount of Payments to Date: \_\_\_\_\_

**Claims Representative:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Legal Claims Asserted:** \_\_\_\_\_

Extent of Physical and Financial Injury: \$ \_\_\_\_\_

Is this case taken on a contingency basis?..... yes..... no (circle one)

If yes, what percentage? \_\_\_\_\_

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WORKER'S COMP INFORMATION (if applicable)

Employer: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Weekly Benefit: \_\_\_\_\_ No. of Weeks: \_\_\_\_\_

Amount Paid to Date: \_\_\_\_\_ Weeks Remaining: \_\_\_\_\_

Previous WC claim? ..... yes ..... no (circle one)

Has client returned to work? ..... yes ..... no (circle one)

If yes, when? \_\_\_\_\_

COSTS TO DATE

Current Medical: \_\_\_\_\_ Estimated Future Medical: \_\_\_\_\_

Case Expenses to date: \_\_\_\_\_ Estimated Future Expenses: \_\_\_\_\_

Lost Wages: \_\_\_\_\_ Estimated Future Lost Wages: \_\_\_\_\_

LIENS

Medical Liens filed to date ..... yes ..... no (circle one)

Amount \$ \_\_\_\_\_

Subrogation Claims? ..... yes ..... no (circle one)

Amount \$ \_\_\_\_\_

Child Support Liens? ..... yes ..... no (circle one)

Amount \$ \_\_\_\_\_

Alimony Liens? ..... yes ..... no (circle one)

Amount \$ \_\_\_\_\_

Tax Liens? ..... yes ..... no (circle one)

Amount \$ \_\_\_\_\_

Prior Loans/Advancements? ..... yes ..... no (circle one)

Amount \$ \_\_\_\_\_

Prior Assignments ..... yes ..... no (circle one)

Amount \$ \_\_\_\_\_

Other Liens (please specify) \_\_\_\_\_

Amount \$ \_\_\_\_\_

DAMAGES

What is the estimated value of the case? \$ \_\_\_\_\_

(Please note that this information will not be revealed to anyone, and we understand that you are offering no guarantees or assurances as to the validity of the case.)

Requested Punitive Damages? ..... yes ..... no (circle one)

Amount \$ \_\_\_\_\_

Requested Compensatory Damages? ..... yes ..... no (circle one)

Amount \$ \_\_\_\_\_

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MEDICAL INFORMATION

Briefly describe the nature and extent of the injuries: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does client have a preexisting condition?..... yes..... no (circle one)

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Has client had previous injury?..... yes..... no (circle one)

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
Name of PCP: \_\_\_\_\_

**Medical Treatment:**

Ambulance Transport?..... yes..... no (circle one)

Emergency Room Visit..... yes..... no (circle one)

When? \_\_\_\_\_

MRI? ..... yes..... no (circle one)

When? \_\_\_\_\_

X-Ray?..... yes..... no (circle one)

When? \_\_\_\_\_

Surgery? ..... yes..... no (circle one)

When? \_\_\_\_\_

Hospital Stay?..... yes..... no (circle one)

Number of days? \_\_\_\_\_

Still in Treatment? ..... yes..... no (circle one)

Describe: \_\_\_\_\_

Medical Costs to Date: \$ \_\_\_\_\_

Has client been a Plaintiff in other lawsuits? ..... yes..... no (circle one)

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## SETTLEMENT INFORMATION

### Status of Case:

Demand Letter Sent..... yes..... **no** (circle one)

Date: \_\_\_\_\_ Amount:\$ \_\_\_\_\_

Settlement Offer Made..... yes..... **no** (circle one)

Date: \_\_\_\_\_ Amount:\$ \_\_\_\_\_

Suit Filed ..... yes..... **no** (circle one)

Date: \_\_\_\_\_

Mediation ..... yes..... **no** (circle one)

Date: \_\_\_\_\_

Arbitration ..... yes..... **no** (circle one)

Date: \_\_\_\_\_

Judgement..... yes..... **no** (circle one)

Amount: \$ \_\_\_\_\_

### Estimated Date of Settlement or Trial:

30 Days

31 to 60 Days

61 to 90 Days

91 days to 6 Months

6 to 9 months

9 months to 1 year

1 year to 18 months

over 18 months

Anticipated Trial Date: \_\_\_\_\_

### DOCUMENTS INCLUDED

The following documents must accompany this report to consider client's funding request:  
(please check all to confirm)

Police Report (if applicable)

Demand Letter

Policy Claim # and Liability Limits

Medical Billing/Statements

Hospital/Emergency Room Reports

Witness Statements

Medical Reports

Pleadings

Expert Witness Statement

Legal Pleadings

### Prepared By:

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Please print and return via mail to:

**Equity Litigation Funding, LLC**

**P.O. Box 21806**

**Lexington, Kentucky 40522-1806**

Or via fax to:

**(859) 268-0115**

For any questions, please call :

**(859) 559-2450.**

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