

Plaintiff Questionnaire



The Merit of Your Case is Your Strongest Asset

(please type or print)

Date: _____

CONTACT INFORMATION

Plaintiff's Full Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone (Day): _____

Telephone (Evening): _____

Telephone (Mobile): _____

e-mail: _____

EMPLOYMENT INFORMATION

Employer Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Occupation: _____

CLIENT HISTORY

Date of Birth: _____

Social Security #: _____

Marital Status: _____

Number of Children: _____

Filed Bankruptcy - Current:..... yes..... no (circle one)

Filed Bankruptcy - Previous:..... yes..... no (circle one)

Have you ever been convicted of a felony?..... yes..... no (circle one)

If yes, explain: _____

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.

ATTORNEY INFORMATION

Law Firm: _____

Attorney's Name _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Fax: _____

e-mail: _____

Fee Arrangement: Hourly Contingency (circle one)

TYPE OF CASE (check all that apply)

Traffic Accident

Product Liability

Medical Malpractice

Sexual Harassment

Commercial Litigation

Premises Liability (slip and fall)

Dog Bite

Discrimination

Wrongful Termination

Nursing Home Neglect

Wrongful Death

Other: _____

Date of Accident or Incident: _____

Briefly Describe What Happened: _____

STATUS OF CASE

Settlement Offer Made to You: yes no (circle one)

How Much? _____

Suit Filed: yes no (circle one)

When? _____

Attempted Mediation: yes no (circle one)

When? _____

Demand Letter Sent: yes no (circle one)

How Much? _____

Judgment: yes no (circle one)

How Much? _____

Amount of Advance Requested: _____

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DAMAGES

Describe your injuries _____

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 \$ _____

Property Damage: _____

Lost Wages?..... yes..... **no** (circle one)

Wages per day: _____

Number of Days Lost: _____

Your Insurance Carrier: _____

Policy Limits: _____

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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