USCLAIMS®

FUNDING APPLICATION

PLAINTIFF

Name:________________________________

Address:________________________________

____

Phone:________________ Cell:________________

Email:________________________________

Social Security #:________________________________

DOB:_____/_____/________ Married? Yes ☐ or No ☐

PLAINTIFF'S COUNSEL

Name:________________________________

Firm:________________________________

Address:________________________________

____

Phone:________________________________

Fax:________________________________

Email:________________________________

INJURIES

Soft Tissue ☐ Sprain/Strain ☐ Herniation ☐

Tear(s) ☐ Fracture ☐ Surgery ☐

Other:________________________________

Pre-existing? Yes ☐ No ☐

Treatment/Surgeries:________________________________

____

CASE INFORMATION

Incident Date:_____/_____/________ State:_______

Case Type: MVA ☐ Slip/Fall ☐ Product Liability ☐

Med Mal ☐ W/C ☐ Premises Liability ☐

Other:________________________________

Accident Description: ________________________________

____

CASE INFORMATION [Cont'd.]

Defendant Name: ________________________________

Police or Incident Report available?: Yes ☐ No ☐

Number of people in accident: ________________

Amount of property damage $________________

Defendant cited? Yes ☐ No ☐

Defendant admit Liability? Yes ☐ No ☐

If no, theory and evidence of liability? ________________

____

Court (if filed):________________________________

Docket/Index#:________________________________

Suit Filed Date:________________________________

Est Settlement Date:_____/_____/________

Demands made? Yes ☐ No ☐ $ ________________

Settle offers made? Yes ☐ No ☐ $ ________________

Amount Requested $ ________________

LIENS

How have medicals been paid? ________________

Total Medicals [Incl. Liens] $ ________________

Other Liens [DPW, Child Support, Workers Comp, Other]:

$ ________________________________

Prior Advances? Yes ☐ or No ☐ $ ________________

Prior Advance Company:________________________________

Workers Comp Liens? Yes ☐ or No ☐ $ ____________

Health Insurance Liens? Yes ☐ or No ☐ $ ____________

INSURANCE INFORMATION

Self Insured? Yes ☐ No ☐ Ins. Verified? Yes ☐ No ☐

Def Insurance Co:________________________________

Def BI Policy Limits:________________ /________________

PIP:________________________________

Plaintiff UM/UIM:________________ /________________

Claim#/Policy#:________________ /________________

Excess Limits: ________________________________

Excess Carrier: ________________________________

The above information is true and correct to the best of my knowledge. **Date:** _____/_____/________

Signature: ________________________________ **Print Name:** ________________________________

(Attorney or Attorney Designee)

Title: ________________________________

PLEASE FAX, EMAIL, OR MAIL DOCUMENTS TO:

1625 South Congress Avenue | Suite 200 | Delray Beach | Florida 33445

Phone: (800) 717-1000 | Fax: (888) 491-3613 | Email: application@usclaims.com

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