



# Accident Victims Funding

*pre-settlement cash advances*

6 Arcadian Drive  
Glenville, NY 12302

1-866-428-3669  
Fax 1-518-372-3613  
julie@accidentvictimsfunding.com

## APPLICATION

PLEASE PRINT CLEARLY AND COMPLETE ENTIRE FORM

### PLAINTIFF INFORMATION

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

Plaintiff Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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

Phone: ( \_\_\_\_ ) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Contact Person, other than household member: \_\_\_\_\_ Phone: ( \_\_\_\_ ) \_\_\_\_\_

How did you hear about us?  Attorney Referral If so, who? \_\_\_\_\_

"Bill of Particulars"

Mailing  Other \_\_\_\_\_

### CLAIM RELATED INFORMATION

The claim shall also include any action or proceeding arising out of or related to the plaintiff's initial injury.

Date of Accident: \_\_\_\_\_

Type of Claim:  Auto  Slip and Fall  Construction  Other – describe:

Description of Accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Location of Accident: \_\_\_\_\_

### INJURIES

Description of Injuries: \_\_\_\_\_  
\_\_\_\_\_

Surgery?: Yes  No  If yes, date: \_\_\_\_\_

Type of Surgery: \_\_\_\_\_

Diagnostic Testing?: Yes  No  Diagnostic Results: \_\_\_\_\_

Prior Injuries: \_\_\_\_\_

**MEDICAL BILLS**

Approximate Total: \_\_\_\_\_

Who Paid?: \_\_\_\_\_

**GOVERNMENT ASSISTANCE**

Social Services? Yes  No  Amount Per Month: \_\_\_\_\_

Social Security? Yes  No  SSI  or SSD  Amount Per Month: \_\_\_\_\_

Worker's Compensation? Yes  No  Amount Per Month: \_\_\_\_\_

Medicaid? Yes  No

Medicare? Yes  No

**EMPLOYMENT HISTORY**

Employed? Yes  No  Occupation: \_\_\_\_\_

Employed at the time of accident? Yes  No  Occupation: \_\_\_\_\_

Time missed from work due to the accident? \_\_\_\_\_

If not employed - Source of Income: \_\_\_\_\_

Received No-Fault wages? Yes  No  For how long? \_\_\_\_\_

**PLAINTIFF'S ATTORNEY AND FIRM:** \_\_\_\_\_

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

Phone: ( \_\_\_\_ ) \_\_\_\_\_

Fax: ( \_\_\_\_ ) \_\_\_\_\_

E-Mail: \_\_\_\_\_

Law Firm Contact Person: \_\_\_\_\_

Will Spouse be a Plaintiff?    Yes  No                       Name: \_\_\_\_\_

Witnesses?                      Yes  No                       Do they support claim?    Yes  No

Other Related Claims: \_\_\_\_\_

**STATUS OF CLAIM**

Is case in suit?                      Yes  No                       If yes, provide the following information:

Title of Action (if commenced): \_\_\_\_\_

Index Number: \_\_\_\_\_

Venue: \_\_\_\_\_ State \_\_\_\_\_ Supreme \_\_\_\_\_ Federal \_\_\_\_\_

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

**DEFENDANT INFORMATION** (Insurance information is needed whether or not in suit)

**Defendant Name (1):** \_\_\_\_\_

Address (1): \_\_\_\_\_

Defense Attorney (1): \_\_\_\_\_

Address (1): \_\_\_\_\_

Insurance Company (1): \_\_\_\_\_

Address (1): \_\_\_\_\_

Telephone: ( \_\_\_\_ ) \_\_\_\_\_ Policy Limits: \_\_\_\_\_ Demand: \_\_\_\_\_

Offer: \_\_\_\_\_ Policy No. \_\_\_\_\_ Claim No: \_\_\_\_\_

**Defendant Name (2):** \_\_\_\_\_

Address (2): \_\_\_\_\_

Defense Attorney (2): \_\_\_\_\_

Address (2): \_\_\_\_\_

Insurance Company (2): \_\_\_\_\_

Address (2): \_\_\_\_\_

Telephone: ( \_\_\_\_ ) \_\_\_\_\_ Policy Limits: \_\_\_\_\_ Demand: \_\_\_\_\_

Offer: \_\_\_\_\_ Policy No. \_\_\_\_\_ Claim No: \_\_\_\_\_

**STATUS OF LITIGATION**

All parties placed on notice: Yes  Date: \_\_\_\_\_ No  Projected Date: \_\_\_\_\_  
All parties sued Yes  Date: \_\_\_\_\_ No  Projected Date: \_\_\_\_\_  
All Parties answered Yes  Date: \_\_\_\_\_ No  Projected Date: \_\_\_\_\_  
Deposition of Plaintiff: Yes  Date: \_\_\_\_\_ No  Projected Date: \_\_\_\_\_  
Deposition of Defendant: Yes  Date: \_\_\_\_\_ No  Projected Date: \_\_\_\_\_  
IME Yes  No   
Note of Issue Filed: Yes  Date: \_\_\_\_\_ No  Projected Date: \_\_\_\_\_  
Trial Date: Yes  Date: \_\_\_\_\_ No  Projected Date: \_\_\_\_\_  
Appeal Filed: Yes  Date: \_\_\_\_\_ No  Projected Date: \_\_\_\_\_

**LIENS/LOANS**

Workers Compensation: Yes  No  If yes, Amount: \_\_\_\_\_  
SSI: Yes  No  If yes, Amount: \_\_\_\_\_  
Welfare: Yes  No  If yes, Amount: \_\_\_\_\_  
H.M.O./Private Insurance: Yes  No  If yes, Amount: \_\_\_\_\_  
Other: \_\_\_\_\_  
Advances from other companies: Yes  No  If yes, Amount: \_\_\_\_\_  
Is client interested in re-finance? Yes  No  If Yes, Amount: \_\_\_\_\_

**THE FOLLOWING MUST BE PROVIDED:**

- 1. ACCIDENT REPORT
- 2. ER RECORDS
- 3. RECORDS FROM FIRST DATE OF TREATMENT AFTER ER
- 4. RADIOLOGY REPORTS
- 5. ALL I.M.E. REPORTS INCLUDING NO FAULT AND WORKERS COMP
- 6. OTHER PERTINENT MEDICAL INFORMATION
- 7. EXPERT REPORTS
- 8. WITNESS STATEMENTS AND INVESTIGATION REPORTS
- 9. WORKERS COMP CASES – C-2 REPORT

AMOUNT OF ADVANCE REQUESTED: \_\_\_\_\_