



**APPLICATION**

**PLAINTIFF INFORMATION**

Date:				Amount Requested:			
Plaintiff Name:							
Address:							
Work Phone:				Date of Birth:			
Home Phone:				Driver's License:			
Mobile Phone:				E-mail:			
Auto Insurance Carrier (auto collisions only):							
UM/UIM?	Yes	No	Limits:	PIP/Med Pay?	Yes	No	Limits:

**INCIDENT INFORMATION**

Date of Injury:							
Type of Claim:	Auto	Slip and Fall	Other -describe				
Description of the Event:							
Location of the Event:							
Description of injuries:							
Property damage paid by adverse carrier?			Yes	No	If so, how much?		
Was there a police report?			Yes	No	<b>(if so, please attach a copy)</b>		
Others injured too?		Yes	No	If yes, what is the value of his/her/their claim(s)?			

**MEDICAL TREATMENT & BILLS (TO DATE)**

<u>Date</u>	<u>Provider</u>	<u>Treatment</u>	<u>Cost</u>	<u>Amt Paid</u>	<u>By Whom?</u>	<u>Balance</u>
<b>TOTALS</b>						

Surgery(ies)?	Yes	No	If Yes, Date(s):	Type(s):
Diagnostic Tests?	Yes	No	Type of test:	Result:
Prior collisions, incidents, injuries or pre-existing conditions, if any:				
Subsequent collisions, incidents, or injuries, if any:				
Client have health insurance?	Yes	No	If so, has it paid any of the expenses?	Yes No
Procedure(s) still needed:				
Estimated cost of such procedure(s):				

**EMPLOYMENT HISTORY**

Currently employed?	Yes	No	Occupation:
Employed at the time of the event?	Yes	No	Occupation:
Time missed from work due to event:			
Current source(s) of income:			

**PLAINTIFF'S ATTORNEY'S INFORMATION**

Firm:			
Address:			
Phone: (    )			
Fax: (    )			
Email:			
Law Firm Contact Person:			
Will Spouse be a Plaintiff?	Yes	No	Name:
Witness(es)?	Yes	No	Name(s):
Other related claims:			

**STATUS OF CLAIM**

Is case in suit?	Yes	No	If Yes, please provide the following information:
Title of Action (if commenced):			
Index/Cause Number:			
Venue:	State	Supreme	Federal
Other Venue:			

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

<b>Defendant Name (1):</b>	
Insurance Company (1):	Claim No.:
Policy Limits:	Demand:
Offer:	
<b>Defendant Name (2)</b>	
Insurance Company (2):	Claim No.:
Policy Limits:	Demand
Offer:	

**STATUS OF LITIGATION**

All parties sued:	Yes	Date:	No	Projected Date
All parties answered:	Yes	Date:	No	Projected Date
Deposition of Parties:	Yes	Date:	No	Projected Date
Trial Date:	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 RANGE OF POSSIBLE RECOVERY:			
HOW MUCH MONEY DOES CLIENT WANT?			

**THE FOLLOWING MUST BE PROVIDED:**

1. ACCIDENT REPORTS
2. WITNESS STATEMENTS
3. PHOTOS OF PROPERTY DAMAGE OR PREMISES DEFECT
4. ALL MEDICAL RECORDS
5. ALL MEDICAL BILLS
6. ANY WORKER'S COMPENSATION RECORDS
7. EXPERT WITNESS REPORTS/LETTERS
8. PARTIES' MOST RECENT DISCLOSURE RESPONSE

Please send to:

LoanStar Legal Funds

ATTN: Lisa

7301 620 North, Ste 155-334

Austin, TX 78725

Office: (512) 266-0097

Fax: (866) 468-5043

email: lisa.loanstar@gmail.com