PARAMOUNT
SETTLEMENT PLANNING, LLC
3686 SENECA STREET, BUFFALO, NY 14224
PHONE: 716-712-0127 FAX: 716-712-0400

DOCUMENT PREPARATION FORM

Please send completed form, as well as supporting documents to lori.nason@planningisparamount.com or fax to 716-712-0400.

PLAINTIFF ATTORNEY INFORMATION

ATTORNEY NAME _____ ASSISTANT/PARALEGAL _____

E-MAIL _____ ASSISTANT/PARALEGAL E-MAIL _____

FIRM NAME _____ PHONE _____ FAX _____

FIRM ADDRESS _____ FIRM TIN _____

REQUIRED CASE INFORMATION IN ADDITION TO THIS FORM PLEASE SEND CASE CAPTION, COPY OF COMPLAINT AND SETTLEMENT STATEMENT TO PARAMOUNT

TYPE OF CLAIM ☐ PERSONAL INJURY ☐ MED MAL ☐ WRONGFUL DEATH ☐ OTHER; SPECIFY _____

ESSENCE OF CLAIM _____ DATE OF LOSS _____

INDEX NUMBER _____ PROPER NAME OF COURT & JUDGE _____

TYPE OF INJURIES SUSTAINED _____

GROSS SETTLEMENT AMOUNT (CASH AND STRUCTURE) $ _____

ATTORNEY FEE STRUCTURE ☐ YES ☐ NO FEE STRUCTURE PAYEE (FIRM OR ATTORNEY) _____

CLAIMANT INFORMATION

CLAIMANT NAME _____ D.O.B. _____ ☐ MALE ☐ FEMALE

S.S.# _____ PHONE _____ E-MAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

GUARDIAN/REPRESENTATIVE'S NAME & TITLE (IF APPLICABLE) _____

NAME OF STRUCTURE PAYEE (TRUST, GUARDIAN, PARENT, PLAINTIFF) _____

STRUCTURE BENEFICIARY'S NAME, D.O.B. & S.S.# _____ _____ _____

CLAIMANT RECEIVING WORKERS' COMPENSATION BENEFITS ☐ YES ☐ NO CLAIMANT RECEIVING SSD BENEFITS ☐ YES ☐ NO

DOES THE CLAIMANT HAVE A MEDICARE CARD ☐ YES ☐ NO ARE YOU INTERESTED IN RESOLVING CLAIMANT'S MEDICARE LIENS ☐ YES ☐ NO

DEFENDANT INFORMATION IS THE DEFENDANT'S INSURANCE COMPANY AWARE OF THE POSSIBILITY OF A STRUCTURE ☐ YES ☐ NO

NAME _____ ATTORNEY NAME _____

ATTY E-MAIL _____ PHONE _____ FAX _____

FIRM NAME _____ FIRM ADDRESS _____

INSURANCE CARRIER'S FULL & PROPER NAME _____ CLAIM # _____

NAME OF ADJUSTER _____ PHONE _____ FAX _____

ADJUSTER ADDRESS _____ E-MAIL _____

CONTRIBUTION TO SETTLEMENT $ _____ CONTRIBUTION TO STRUCTURE $ _____

NAME OF CASH PAYEE (ATTORNEY OR FIRM TRUST ACCOUNT, LIENHOLDERS) _____ AMOUNT $ _____

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NAME _____ ATTORNEY NAME _____

ATTY E-MAIL _____ PHONE _____ FAX _____

FIRM NAME _____ FIRM ADDRESS _____

INSURANCE CARRIER'S FULL & PROPER NAME _____ CLAIM # _____

NAME OF ADJUSTER _____ PHONE _____ FAX _____

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