

Client ID: _____



13911 Ridgedale Drive, Suite 230
Minnetonka, MN 55305
Office: 952-417-8000
Toll Free: 866-417-8001
Fax: 952-417-0039
Email: info@bridge-funds.com

Personal Injury/ Workers' Compensation Application

CLIENT CONTACT INFORMATION

Name: _____ Employer: _____
Home Address: _____ Work Address: _____
City: _____ City: _____
State: _____ Zip: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Home Fax: _____ Work Fax: _____
Cell Phone: _____ E-mail: _____
E-mail: _____

PERSONAL CLIENT DATA

Date of Birth: _____ Spouse Name: _____
Marital Status: S M D W Age of Child(ren): _____
Child(ren): __ Yes __ No Monthly Child Support: \$ _____
Child Support: __ Yes __ No When Filed: _____
Current Bankruptcy: __ Yes __ No When Filed: _____
Previous Bankruptcy: __ Yes __ No Explain: _____
Criminal Record: __ Yes __ No Employer _____
SSN: _____ Occupation _____
Monthly Salary \$ _____

ATTORNEY INFORMATION

Name: _____ Law Firm: _____
Address: _____ Phone: _____
City: _____ Fax: _____
State: _____ Zip: _____ E-mail: _____
Fees: Contingent _____ % Hourly: \$ _____
Recovery to be deposited in Trust Account: __ Yes __ No

TYPE OF CASE

- Auto Accident
- FELA/Jones Act
- Medical Malpractice
- Premises Liability
- Product Liability
- Workers' Compensation
- Other

CASE DETAILS

Briefly describe the facts of the case. _____

ACCIDENT INFORMATION

Date of Accident/Injury: _____ Time of Accident/Injury: _____ AM/PM

Citations/Tickets: __ Yes __ No DWI/DUI: __ Yes __ No

You: __ Yes __ No You: __ Yes __ No

Other Party: __ Yes __ No Other Party: __ Yes __ No

Name of Police Department: _____

INJURY INFORMATION

Briefly describe the nature and extent of injuries. _____

MEDICAL INFORMATION

Name of Physician(s): _____ Chiropractic Treatment: __ Yes __ No

Are You Currently Treating? __ Yes __ No If Yes, (Chiro) are You Still Treating? __ Yes __ No

Pre-Existing Conditions: __ Yes __ No If Yes, Explain: _____

Previous Injuries: __ Yes __ No If Yes, Explain: _____

Prior Settlements: __ Yes __ No If Yes, Explain: _____

Future Medical Treatment Expected: __ Yes __ No If Yes, Explain: _____

Was an MRI done? __ Yes __ No If Yes, Result: _____

Who is paying your medical bills now? _____

INSURANCE INFORMATION

Your Insurer: _____ Negligent Party(s) Insurer: _____
Policy Limit: _____ Policy Limit: _____

WORKERS' COMPENSATION INFORMATION (if applicable)

Employer: _____ Insurance Co.: _____
Weekly Benefit: _____ No. of Weeks: _____
Amount Paid to Date: \$ _____ No. of Weeks: _____
Previous WC Claims: ___ Yes ___ No Explain: _____
Client Returned to Work: ___ Yes ___ No If No, Expected Date: _____
Are Benefits Being Paid? ___ Yes ___ No If Yes, Amount: \$ _____

LIENS AND OTHER ENCUMBRANCES

Child Support Liens: ___ Yes ___ No \$ _____
Alimony Liens: ___ Yes ___ No \$ _____
Tax Liens: ___ Yes ___ No \$ _____
Prior Loans/Advances: ___ Yes ___ No \$ _____
Other (i.e. Medical) _____ \$ _____

SETTLEMENT INFORMATION

Settlement Offer Made: \$ _____ Date of Offer: _____
Estimated Settlement Date: _____

FUNDING REQUEST

Amount: \$ _____

USE OF FUNDS

Personal Debts: ___ Yes ___ No \$ _____
Case Costs: ___ Yes ___ No \$ _____
Attorney's Fees: ___ Yes ___ No \$ _____
Other: ___ Yes ___ No \$ _____

OTHER COMMENTS

Please provide any additional information regarding liability, damages and/or collectibility.

PREPARED BY

Print Name: _____ Date: _____

Signature: _____

CONFIDENTIALITY NOTICE: All information provided herein is for underwriting purposes only. All information shall be held in strict confidence and shall not be disclosed to any third party unless so instructed to do so by client, counsel or court order.

Records & Information Release



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Dear Attorney _____:

I/We, the undersigned, hereby request and authorize your firm to cooperate and release to BridgeFunds, LLC any and all information and documents pertaining to my/our current claim or lawsuit, including pleadings, discovery, investigation, contacts, medical records/reports, depositions and all other information not protected by the attorney-client privilege, the work product doctrine or other applicable evidentiary privileged or protections.

I/We request and instruct you to share your candid opinion(s) regarding my/our claim or lawsuit with BridgeFunds, LLC, its representatives and agents.

A copy of this authorization bearing the signature of the undersigned may be deemed to be the equivalent of the original.

Thank you in advance of your cooperation.

Print Name: _____ Date: _____

Signature: _____ SSN: _____

Client ID: _____

Client Information Release



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To BridgeFunds, LLC:

BridgeFunds and its representatives are hereby authorized to gather any information about me/us required to complete your due diligence investigation regarding a requested financial transaction by me/us. Such information may include, but is not limited to, financial and credit information, consumer credit reports and any information concerning liens and judgments against me/us.

A copy of this authorization bearing the signature of the undersigned may be deemed to be the equivalent of the original.

Thank you in advance of your cooperation.

Print Name: _____ Date: _____

Signature: _____ SSN: _____

Telephone No: _____ Date of Birth: _____

Address:

City: _____ State: _____ Zip: _____

E-mail: _____

**Authorization for the Release of
Workers' Compensation File Materials**



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TO: ANY PERSON/ENTITY/OFFICE OR DEPARTMENT IN POSSESSION OF WORKERS'
COMPENSATION INFORMATION

RE: _____

SSN: _____

DOB: _____

I hereby authorize BridgeFunds LLC, their representatives or employees to review and/or copy any and all materials regarding my Workers' Compensation file in the possession of your office.

This information is needed for claim evaluation purposes. This authorization specifically includes records prepared prior to the date of this authorization and records prepared after the date of this authorization during the pendency of this proceeding (including claims and potential claims). I do not authorize release of this information by the third party.

I understand that I may revoke this consent in writing at any time, but that such revocation may adversely affect the course of the proceeding requiring these records. Upon fulfillment of the above stated purpose, this consent will automatically expire without my express revocation. **A PHOTOCOPY OF THIS AUTHORIZATION WILL BE TREATED IN THE SAME MANNER AS AN ORIGINAL.**

Signature: _____

Date: _____