

**PLAINTIFF'S CASE
INFORMATION SHEET FOR FILE**

<p>Client Name, Maiden Name, Aliases:</p>	<p>Date of Injury:</p> <p>Date that Plaintiff Knew or Reasonably Should Have Know of Claim:</p>
<p>Location Where Loss Occurred:</p> <p>County:</p>	<p>Defendants(s):</p> <p>County of Residency:</p>
<p>Statute of Limitations For Liability Claim:^{1, 2}</p>	<p>Date Complaint Filed:</p> <p>Date Service Obtained:</p> <p>Return of Service File With Court:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Tort Claim Notice Needed? (U.S. government agency, state level public body, dram shop, ski facility, etc.)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Date Tort Claim Notice Sent:</p>
<p>Motor Vehicle Accident?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hit-and-Run Vehicle or Possible "Phantom Vehicle" Involved?³</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was Client Pedestrian or Bicyclist When Injured by Motor Vehicle?⁴</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Client's Insurance Limits:⁵</p> <p>PIP Insurance Limits:</p> <p>UM/UIM Insurance Limits:</p> <p>Umbrella Insurance Limits:</p>

<p>Statute of Limitations for UM/UIM Claim:⁶</p>	<p>Date Notice of UM/UIM Claim Sent:⁷</p> <p>Insurer Agreed to Binding Arbitration: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date of Safe Harbor Letter:</p> <p>Date Arbitration Formally Instituted or Suit Filed Against Insurer:⁸</p>
<p>Is Client Medicare Eligible? ⁹</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, Client's Medicare HIC #:</p> <p>Will Client Likely Become Eligible Within 30 Months of Any Settlement?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>*If Yes, Consider Where Set Aside Required</p>	<p>Date Notice of Claim Sent to Medicare CMS COB:¹⁰</p> <p>Date Conditional Payment Letter Received:</p> <p>Is Set-Aside Required?:</p>
<p>Does Client Receive Medicaid Benefits?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has Notice of Claim Been Provided? ¹¹</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Has Client Received Crime Victim Compensation Program Benefits?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has Notice of Claim Been Provided? ¹²</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Does Client Have Health Insurance?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If So, Is It an ERISA Plan?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has Notice of Claim Been Provided?¹³</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Has Client Received Workers' Compensation Benefits?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has Notice of Claim Been Provided? ¹⁴</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Other Possible Sources of Leins:</p>	

Client Information

Names of client's spouse, significant other, and family members:	Client's Employer(s):	
Emergency Contacts (name, address, phone, email)		
Client's Address:	Client's DOB:	
Client's Bankruptcy Status: ¹⁵	Home Phone:	
Cell Phone:	E-mail:	SS#:
Social Media Accounts (Facebook, Twitter, Instagram, etc.):	Blogs/Web Sites:	Work Phone:
Criminal Convictions?:	Prior Marriages?:	Prior Injury Claims?:

Case Information

Client Referred By:		Referral Fee Due? <input type="checkbox"/> Yes <input type="checkbox"/> No	Referral Fee Amount:
Fee Agreement Executed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Guardian or conservator Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Need for guardian or conservator disclosed to client? <input type="checkbox"/> Yes <input type="checkbox"/> No	Conflict Check Done <input type="checkbox"/> Yes <input type="checkbox"/> No
Retainer Received:	Employment and Financial Information Authorization: <input type="checkbox"/> Yes <input type="checkbox"/> No HIPAA-Complaint Authorization: <input type="checkbox"/> Yes <input type="checkbox"/> No	Related Cases or Co-Plaintiff(s):	

PIP/No Fault Insurer

Carrier:	Policy No.:
	Claim No.:
Adjuster:	Telephone:
	E-Mail:
Lawyer(s):	Telephone:
	E-Mail:
PIP Insurer's Recovery Election? ¹⁶ <input type="checkbox"/> Inter-Company Arbitration / Self Recovery <input type="checkbox"/> Lien <input type="checkbox"/> Reimbursement from Client <input type="checkbox"/> No Election Made	Representation Letter Sent? <input type="checkbox"/> Yes <input type="checkbox"/> No Confirmation of PIP Insurer's Recovery Election Sent? <input type="checkbox"/> Yes <input type="checkbox"/> No Copy of Complaint sent to PIP carrier via certified mail? <input type="checkbox"/> Yes <input type="checkbox"/> No
Billings / Payments Ledger Received: <input type="checkbox"/> Yes <input type="checkbox"/> No	Benefits Exhaustion Letter Received: <input type="checkbox"/> Yes <input type="checkbox"/> No

Total Lien Amount:	Reduction or Discount:	Date of Last Update:	Amount Due Verified in Writing?
Notes:			

UM/UIM & Property Damage Insurer

Carrier:	Policy No.:
	Claim No.:
Adjuster:	Telephone: E-Mail:
Lawyer(s):	Telephone: E-Mail:
Policy Limits:	Does Jurisdiction allow for UM/UIM stacking?
Copy of Insurance Policy & Declarations Sheet Received? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does Policy Exclude Diminished Value Property Damage Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If Not, Should ORS 20.082 Demand Letter for Diminished Value Claim Be Sent? <input type="checkbox"/> Yes <input type="checkbox"/> No
Notes:	

Defendant Number 1:

Defendant Number 1:	Liability Insurer:
	Claim No.:
Address:	Additional Liability Insurer:
Website:	Claim No.:
Defense Attorney(s):	Phone: Fax: E-Mail:
Excess Attorney(s):	Phone: Fax: E-Mail:
Liability Insurance Adjuster:	Phone: Fax: E-Mail:
Secondary Liability Insurance Adjuster:	Phone: Fax: E-Mail:

Defendant Number 2:

Defendant Number 2:	Liability Insurer:
	Claim No.:
Address:	Additional Liability Insurer:
Website:	Claim No.:
Defense Attorney(s):	Phone: Fax: E-Mail:
Excess Attorney(s):	Phone: Fax: E-Mail:

Liability Insurance Adjuster:	Phone: Fax: E-Mail:
Secondary Liability Insurance Adjuster:	Phone: Fax: E-Mail:

Defendant Number 3:

Defendant Number 3:	Liability Insurer: Claim No.:
Address: Website:	Additional Liability Insurer: Claim No.:
Defense Attorney(s):	Phone: Fax: E-Mail:
Excess Attorney(s):	Phone: Fax: E-Mail:
Liability Insurance Adjuster:	Phone: Fax: E-Mail:
Secondary Liability Insurance Adjuster:	Phone: Fax: E-Mail:

Witness Information

Name	Address	Telephone	Interviewed	Date Subpoenaed
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Initial Evidence to Obtain

- Have all recorded statements to any insurer or investigator been obtained? Yes No
- Have any Oregon DMV accident reports been obtained? Yes No
- Have any 911 tapes been obtained? Yes No
- Have any police reports been obtained (including officer field notes, photos, etc.)? Yes No
- Does client have photographs of injuries, the scene of the accident, or any vehicles involved? Yes No
- Has client kept a diary or journal since the injury? Yes No
- Have property damage estimates and photos from insurers been obtained? Yes No
- Has background check for client been obtained? Yes No

Medical Information

Medical Reports and Hospital Records

Provider	Date Requested	Date Received	Date Produced

Doctor Information

Name	Address	Telephone Conf.	Trial Notice	Date Subpoenaed

Settlement Information/Checklist

Does UM/UIM carrier require written consent to settle with underlying defendant(s)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, has Consent been obtained?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does workers comp carrier require written consent to settle with underlying defendant(s)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, has Consent been obtained?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did client have health insurance coverage through a private carrier? Examine the health insurance policy for provisions requiring repayment of funds or denial of coverage for injuries that have been the subject of a personal injury settlement.				
Has this been evaluated?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Considered affect of settlement on client's eligibility for public benefits: ¹⁷				
Welfare:			<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Social Security Disability:			<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Supplemental Security Income:			<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Workers Compensation: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Medicaid: <input type="checkbox"/>			<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Workers Comp. Lien:	Contact:	Telephone:		
Medicaid Lien:	Contact:	Telephone:		
Medicare Lien:	Contact:	Telephone:		
Oregon Health Plan Lien:	Contact:	Telephone:		
Crime Victims Compensation Fund Lien:	Contact:	Telephone:		
Welfare Lien:	Contact:	Telephone:		
Other Lien (specify):	Contact:	Telephone:		

Settlement Offers

Party & Date	Amount	Relayed to Client	Responded to Opposing Party

**Medical Bills Owed
(Including Hospital and Medical Providers)**

Name of Entity	Amount Due	Discount Allowed	Lien Filed	Date of Last Update	Amount Due Verified in Writing?

Costs

Type	Amount	Provider	Telephone
Deposition			
Filing Fees			
Medical Report Copies			
IME			

Pleading Chronology

Document	Date Filed/Served
Complaint	
Summons	
Motion to Strike	
Request for Production	
Request for Admissions	
Discovery Supplemented (ORCP 43 B)	
Summary Judgment (60 days before trial. ORCP 47 C)	

Hearing and Trial Date Chronology

Hearing	Date Client Notified
Motion for Summary Judgment (see above)	
Trial	

¹ For a compilation of various Statutes of Limitations go to www.osbplf.org and download the Oregon Statutory Time Limitations Handbook. Select Practice Management > Publications.

² Note that in addition to any applicable “discovery rule” statutory provision that may effect the tolling of a statute of limitations, an advance payment of insurance proceeds on the adverse party’s behalf may extend the statute of limitations period, per ORS 12.155.

³ Note the notice requirements set forth at ORS 742.504(2)(b) & (g).

⁴ If so, consider ORS 742.520(1). The client’s or the adverse party’s Personal Injury Protection (PIP) insurer may be required to pay medical and/or wage loss benefits.

⁵ Note that some jurisdictions outside of Oregon allow for “stacking” of UM/UIM and/or PIP policy limits. Jurisdictions can allow for intra-policy stacking, inter-policy stacking, and/or UM/UIM stacking upon any liability insurance proceeds obtained from a tortfeasor. Consult applicable law in the relevant jurisdiction. For articles about potential malpractice traps involving liens, PIP benefits, stacking of coverage, and related issues, search the PLF website, www.osbplf.org.

⁶ See ORS 472.504(2)(g) & (12).

⁷ For a discussion of what constitutes “proof of loss” for a UIM claim see recent decision in *Zimmerman v. Allstate Property and Casualty Insurance Company*, (Or, 2013).

⁸ See ORS 742.504(12).

⁹ Note that your client may be Medicare eligible even if they are under the age of 65. For instance, if the client has received Social Security Disability income payments for 24 months, he or she is automatically eligible for Medicare coverage regardless of age.

¹⁰ See: www.cms.gov

¹¹ See ORS 416.530 and OAR 461-195-0310.

¹² See ORS 147.283.

¹³ See ORS 742.536.

¹⁴ See ORS 656.576-596.

¹⁵ Personal injury claims must be fully disclosed in bankruptcy and included as an asset on Schedule B (Personal Property Schedule). Failure to disclose a personal injury claim in bankruptcy can result in permanent dismissal of the claim. Use PACER (Public Access to Court Electronic Records) to check for bankruptcy filings. Contact the US Bankruptcy Court at 503-326-2231 for more information if needed. See Personal Injury Claims and Bankruptcy, PLF *In Brief*, February 2008. Available online at www.osbplf.org.

¹⁶ PIP Insurers have three options for the recovering the PIP benefits it has paid. See ORS 742.534(5). It may seek reimbursement directly from the liability carrier pursuant to ORS 742.534, it may elect to assert a lien on any third party recovery pursuant to ORS 742.536, or it may elect reimbursement from the insured pursuant to ORS 742.538. If either of the latter two options are chosen the PIP carrier must pay its *pro rata* share of attorney fees and costs incurred by the insured in achieving recovery. See ORS 742.536(3)(a) and ORS 742.538(1).

¹⁷ If client’s public benefits or eligibility for receiving public benefits in the future may be effected by a recovery, consider setting up a Special Needs Trust for clients under the age of 65 or a Pooled Special Needs Trust for clients 65 years of age or older. The risks and benefits of such an approach should be fully discussed with client including what things the trust funds can be used to purchase or pay for.

IMPORTANT NOTICES

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