



# Simia Capital

## Application for Sale of Personal Injury Claim Proceeds

### Claimant Information

Name: \_\_\_\_\_  
AKA: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State & Zip: \_\_\_\_\_  
Social Security No: \_\_\_\_\_  
Marital Status: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Home #: \_\_\_\_\_  
Cell #: \_\_\_\_\_  
Email: \_\_\_\_\_  
Injuries: \_\_\_\_\_  
Treatment: \_\_\_\_\_

### Plaintiff's Counsel

Attorney Name: \_\_\_\_\_  
Firm Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State & Zip: \_\_\_\_\_  
Office#: \_\_\_\_\_  
Fax#: \_\_\_\_\_  
Cell#: \_\_\_\_\_  
Email: \_\_\_\_\_

### Case Information

I understand that the information contained herein is being relied upon by **SIMIA CAPITAL, LLC** and other entities. It is complete and accurate in all material respects. With submission of this application, I hereby certify that the foregoing statements are true. I am aware that if any of the foregoing statements are willfully false, I am subject to punishment. I am aware that the information contained herein is incorporated by reference into the Assignment Documents and that submission of this application constitutes authorization to send to outside sources. I understand that by signing the Assignment Documents and this Application, I am also certifying the contents of this Application without the need for independently executing this document.

Accident Date: \_\_\_\_\_  
Case Type: (Auto, Medical, Premises etc.) \_\_\_\_\_  
Case Name: \_\_\_\_\_  
Docket/Index#: \_\_\_\_\_  
Suit Filed Date: \_\_\_\_\_  
Estimated Date of Settlement: \_\_\_\_\_  
Medical Liens: \_\_\_\_\_  
Other Liens (DPW, Child Support, Workers Comp, Other): \_\_\_\_\_  
Prior Advances: \_\_\_\_\_  
Prior Advance Company: \_\_\_\_\_  
New Advance Amount Requested: \_\_\_\_\_  
Settlement Offers: \_\_\_\_\_

### Settled Cases

Settlement Amount: \_\_\_\_\_  
Date Settled/Net Proceeds: \_\_\_\_\_  
Est Disbursement Date: \_\_\_\_\_

### Defendant Information

Defendant Name: \_\_\_\_\_  
Insurer Name: \_\_\_\_\_  
Policy Limits: \_\_\_\_\_ / \_\_\_\_\_  
Claim#/Policy#: \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

800-

phone /201-

Fax