**SF-DCT REVISED PROOF OF LIEN FORM**

**FOR ALLOWABLE FEES AND/OR EXPENSES**

**Read these Instructions carefully. Failure to follow them will result in the return of the form to you without a decision.**

**INSTRUCTIONS: File one Proof of Lien form for each claimant. Do not combine multiple claimants on one form or the form will be returned to you without a decision. PRINT legibly and attach itemized documentation of allowable expenses only. See attached Q&A’s.**

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| --- | --- |
| 1.Name of Law Firm / Entity Asserting a lien | 2. Applicable Tax ID, EIN, or SSN of person asserting a lien |
| 3. Name of Contact Person at Law Firm / Entity Asserting a Lien | |
| 4. Address (Street, City, State, Zip) | |
| 5. Telephone Number: | 6. Email: |
| 7. Name and address (last known) of Claimant against whom you are asserting a lien. | |
| 8. Provide at least **one** of the following: SID #, SSN, or Proof of Claim # (preferably in this order) of claimant against whom you are asserting a lien | |
| 9. Check one of the following:  □ I am an attorney who represented the claimant on one or more of her benefit payments. Go to Q10.  □ I am NOT an attorney but I am asserting a lien for medical expenses. Go to Q12. | |
| 10. □ I am asserting a lien for ATTORNEY FEES per the schedule in the Plan. (Complete the following questions. Check all boxes to which the lien applies, including future payments such as Premium and Increased Severity Payments. Failure to check applicable boxes now will be deemed a waiver of the right to assert a lien of these payments in the future.)  Date representation began:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date representation terminated (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Attach a copy of the contract of representation and letter terminating representation (if applicable).   |  |  |  | | --- | --- | --- | | Check which payment(s) the lien applies to |  | Amt. Attorney Fee Claimed with this lien | | Rupture Payment |  |  | | Rupture Premium Payment |  |  | | Disease Payment |  |  | | Disease Premium Payment |  |  | | Increased Severity Disease Payment |  |  | |  |  |  | | Increased Severity Disease Premium Payment |  |  | | |
| 11. Have you previously received attorney fees for this Claimant (including any fees from benefit payments made in the Revised Settlement Program)? If so, state the amount of the benefit awarded to claimant, the amount of attorney fees paid to you, and the date the fees were paid.  Claimant Award Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_ Attorney Fees Paid to You: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Claimant Award Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_ Attorney Fees Paid to You: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Attach additional pages if necessary.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  12. I am asserting a lien for ALLOWABLE EXPENSES. You must provide ITEMIZED documentation for each expense. You must include all allowable expenses incurred as of the date of the lien submission. You can amend this form for allowable expenses but only for expenses incurred ***after*** the date this form was submitted.   |  |  | | --- | --- | | Period of time Claimed Expenses were incurred | Total Amount of Allowable Expenses Claimed | | \_\_\_\_\_\_\_\_\_, \_\_\_\_\_ to \_\_\_\_\_\_\_\_\_,\_\_\_\_\_  (mo/day/ year) (mo/day/ year) | $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   **ATTACH an itemized list that clearly identifies the type of allowable expense, amount, and date the expense was incurred. Do not submit any other documentation except for the itemized list. Do not include non-allowable expenses on the itemized list. This will delay the decision on your lien claim and possibly result in this claim being returned to you without a decision.**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  13. Have you previously received reimbursement for expenses for this Claimant? No. Yes. If so, state the date and amount of payment that was received and whether it satisfied all outstanding allowable expenses at the time.  Were all prior reimbursements  for allowable expenses only?    Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  14. **□** Check this box if you are asserting a lien for attorney fees and/or expenses because you either cannot locate your client to distribute a payment or are unable to distribute a payment because the claimant is deceased. **You must have returned the entire claimant award(s) in question to the SF-DCT before your lien will be reviewed**. On a separate piece of paper, describe the efforts you have taken to locate your client, the last known address and contact information for the client, and/or any contact information for heirs and/or probate administrators and representatives, if applicable. The statement must include a reason why you cannot distribute the claimant’s payments directly to the claimant.  If you are terminating your representation of the claimant for the reason(s) noted above, you must notify the SF-DCT in writing when you submit this Proof of Lien form. | |
| **15. CERTIFICATION: SIGN AND DATE**  **Forms that are not signed will be returned and the lien will not be reviewed.**  I declare under penalty of perjury that the above information and statements are true, correct, and accurate.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Person asserting a lien Date signed  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed name Position  **DEADLINE: You must return this completed, signed Proof of Lien form on or before 30 days from the date the form was sent to you by the SF-DCT. If you have any questions about your deadline, contact the SF-DCT.** | |