

STATE BAR OF MICHIGAN

OFFICE USE ONLY

# CLIENT PROTECTION FUND

## CLAIM APPLICATION



CLIENT PROTECTION FUND

All members of the State Bar of Michigan are urged to give assistance, without fee, to any claimant presenting a claim to the Client Protection Fund. Claimants are advised that, except in unusual circumstances, the assistance of an attorney is not necessary in filing a claim since the State Bar has staff available which will investigate the facts. The Client Protection Fund is not a substitute for malpractice insurance or a fee adjustment service.

The State Bar of Michigan does not acknowledge any legal responsibility for the acts of individual lawyers in their practice of law. All reimbursements of losses by the Client Protection Fund are a matter of grace in the sole discretion of the Board of Commissioners, and are not a matter of right. No person shall have any right in the Client Protection Fund as a third party beneficiary or otherwise.

Answer every question on this application. If there is not enough room, attach additional pages and label your answer using the question number and letter.

**WHEN COMPLETED, SIGN THE FINAL PAGE OF THIS FORM AND RETURN TO:**

**State Bar of Michigan  
Client Protection Fund  
306 Townsend Street  
Lansing, MI 48933-2012  
(800) 968-1442 or (517) 346-6379**

**Answer every question in this application. If more space is needed, please attach additional pages.**

**1. Person Filing Claim ("Claimant") Information:**

Mr. Mrs. Ms. Name: \_\_\_\_\_  
Name of spouse: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone (Home): (\_\_\_\_) \_\_\_\_\_ Telephone (Cell): (\_\_\_\_) \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Social Security No: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Name of Employer: \_\_\_\_\_  
How did you learn about the Client Protection Fund? AGC \_\_\_ Website \_\_\_ Other: \_\_\_\_\_

**2. Attorney you allege has caused you a loss:**

a. Name: \_\_\_\_\_  
Name of law firm: \_\_\_\_\_  
Business address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
Business telephone: \_\_\_\_\_  
Home address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

b. Were there any other attorneys employed and/or working at the law firm? Yes No

c. If so, please provide their name(s): \_\_\_\_\_  
\_\_\_\_\_

**3. Have you previously filed a claim with the Client Protection Fund? Yes No**

If yes, state approximate date of submission: \_\_\_\_\_  
Name of attorney: \_\_\_\_\_  
\_\_\_\_\_  
Was the claim: Approved Denied

**4. Nature of attorney/client relationship:**

a. Date the attorney was first contacted:  
\_\_\_\_\_

b. Reason you contacted the attorney:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. What fees were agreed upon, and how and when was the attorney to be paid?  
\_\_\_\_\_  
\_\_\_\_\_

d. How much did you actually pay the attorney?  
\_\_\_\_\_  
\_\_\_\_\_

e. Did you pay court costs or filing fees in advance?  
Yes  No   
If yes, how much? \$ \_\_\_\_\_

f. When and how were such payments made?  
\_\_\_\_\_  
\_\_\_\_\_

**Answer every question in this application. If more space is needed, please attach additional pages.**

**5. Claimant's Loss:**

*(Do not include money spent trying to recover the funds or properties, interest, pain and suffering or other damages.)*

a. Amount misappropriated by the attorney (**dollar amount**): \_\_\_\_\_

b. Date the misappropriation occurred (**must be a date**): \_\_\_\_\_

c. Date you discovered the misappropriation (**must be a date**): \_\_\_\_\_

d. Describe how you discovered the misappropriation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

e. Was this loss reported to the:  Police  District Attorney  City Attorney  
 FBI  Attorney General

If reported, state when, where, and to whom you. (Attach a copy of the report). \_\_\_\_\_

\_\_\_\_\_

f. Describe in specific detail how the loss occurred: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

g. List the name, address, and telephone number of any other person(s) who have specific knowledge of this loss:

_____	_____
_____	_____
_____	_____

**6. Legal Service Information:**

a. How many times did you meet with the attorney? \_\_\_\_\_

b. Briefly describe what was discussed during each meeting and what happened. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Answer every question in this application. If more space is needed, please attach additional pages.**

c. Briefly describe what was discussed during each telephone conversation with the attorney or law office. \_\_\_\_\_

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d. List the services performed by the attorney. \_\_\_\_\_

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e. State the services you feel the attorney failed to perform. \_\_\_\_\_

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f. What is the status of your case at this time? \_\_\_\_\_

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g. Did the attorney handle any other legal work for you? Yes No

If yes, please provide the approximate date and a short description of the work performed: \_\_\_\_\_

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h. Did you hire a new attorney to complete your case? Yes No

If yes, provide the name and address of the attorney. \_\_\_\_\_

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**7. Claimant: Please complete the following questions and statements:**

a. Did the loss occur within the context of your attorney-client relationship? Yes No

b. At the time of the loss, or when the loss was discovered, were you related to the attorney (i.e., spouse,

relative, partner, employee)? Yes No

If yes, state the relationship: \_\_\_\_\_

**Answer every question in this application. If more space is needed, please attach additional pages.**

c. Have you asked the attorney to reimburse you? Yes No If yes, attach a copy of the letter.

d. Have you been reimbursed for any part of the claim? Yes No

If yes, Amount: \_\_\_\_\_ Date received: \_\_\_\_\_ Received from: \_\_\_\_\_

Amount: \_\_\_\_\_ Date received: \_\_\_\_\_ Received from: \_\_\_\_\_

e. Have you filed a claim with a bonding or insurance company to recover for the loss? Yes No

If yes, were you reimbursed? Yes No

If yes, Amount: \_\_\_\_\_ Date received: \_\_\_\_\_ Received from: \_\_\_\_\_

f. Have you filed a Request for Investigation with the Attorney Grievance Commission? Yes No

If yes, provided the Date Submitted: \_\_\_\_\_ File Number: \_\_\_\_\_

g. Has the attorney died? Yes No If yes, Date of Death: \_\_\_\_\_

Has the attorney been adjudged incapacitated? Yes No

Has the attorney been suspended from the practice of law? Yes No If yes, Date: \_\_\_\_\_

Has the attorney been disbarred from the practice of law? Yes No If yes, Date: \_\_\_\_\_

h. Has the attorney or the attorney's law firm filed Bankruptcy? Yes No

If yes, please attach copies of all bankruptcy documentation received.

i. State, if known, whether any civil and/or criminal proceedings have been, or will be, commenced in connection with the facts set out in this application. Yes No

If yes, please provide:

Court name: \_\_\_\_\_ Court file no.: \_\_\_\_\_

Party names: \_\_\_\_\_

j. Will you be applying to any other state for reimbursement from its Client Protection Fund? Yes No

**8. Name and address of the lawyer or other person currently representing or assisting you with this application.**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**9. Have you attached copies of the following documents? Do not send originals**

a. The retainer or fee agreement? Yes No

b. Receipts, *cancelled* checks, credit card statements, or invoice reflecting payment and charges? Yes No

**Answer every question in this application. If more space is needed, please attach additional pages.**

c) Did you retain the attorney to represent you in a lawsuit? Yes No

If yes, did you include copies of court documents? Yes No

If no, please provide: Court name: \_\_\_\_\_ Court Case No.: \_\_\_\_\_

Court Address: \_\_\_\_\_

d) Did the attorney prepare other legal papers for you? Yes No If yes, please attach copies.

e) Attach copies of any other relevant documents that support your claim. Include a copy of the police report, bankruptcy notice from the attorney, and the letter requesting reimbursement from the attorney, if applicable.

**10. This claim is executed and filed in order to induce the State Bar of Michigan to process and investigate it and to consider in its sole discretion the making of payment from the Client Protection Fund to the claimant.**

Claimant agrees to cooperate in the investigation of this claim and also in any related disciplinary proceedings against the lawyer(s) in question; and, as a condition precedent to any payment from the Fund, claimant agrees to give to the State Bar of Michigan all information requested.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Claimant



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State Bar of Michigan  
306 Townsend Street  
Lansing, MI 48933-2012  
(517) 346-6300  
[www.michbar.org](http://www.michbar.org)