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An Outline of Required Information for Estimating the Economic Value of the Loss of Dependent Support, the Loss of Net Accumulations to the Estate and the Loss of Household Services Occasioned by the Death of an Individual

PLEASE COMPLETE AND RETURN ALL FORMS & ATTACHMENTS

I. Background and Case Information

A. Name of decedent: _____

B. Race: White_____Black_____African American_____Other_____(please specify)

C. Sex/Gender: _____

D. Date of birth: _____

E. Date of incident or injury (and initial date of earnings loss or impairment, if different from date of death): _____

F. Date of death: _____

G. Trial date: _____

H. Mediation date: _____

I. Family Members ***Who Have Claim(s)*** for Loss of Financial Support and/or Loss of Services.

Please include only Statutory Survivors

Name of Claimant	Relationship to Decedent	Date of Birth	Claim For Financial Support? (please check)	Claim for Loss of Services? (please check)

PLEASE FORWARD THE FOLLOWING:

J. Please indicate if this analysis is to be calculated under:

1. Florida Wrongful Death Act §768.21 Yes_____ No _____

2. Federal Court (i.e., Rule 26) Yes_____ No _____

3. Non-Florida Case (please provide the State's damages portion of their Wrongful Death Statutes).

K. Copy of Complaint.

L. Copy of the Death Certificate.

M. A copy of the decedent's most recent Social Security Statement (sent annually by the Social Security Administration to all workers) reflecting their entire work-life history of earnings. The Social Security Statement is a concise personal record of the earnings on which the decedent has paid Social Security taxes during his/her working years and provides a summary of the estimated benefits he/she may receive as a result of those earnings.

N. Previous occupational and earnings history (i.e. preferably copies of the income tax returns **with** all W-2 Forms, 1099 Forms, and SSA-1099 Forms for the five years prior to and including the year of death). In case of a self-employed individual, please include Schedule C (or Schedule F if farming activity) of Form 1040.

O. If applicable, please provide copies of business tax returns (i.e. Form 1120S, etc.) including all Schedule K-1 forms for the five years prior to and including the year of death).

P. Verification of his/her rate of pay (i.e. copies of pay stubs; payroll records; personnel records).

Q. Verification of the decedent's employer's contributions to fringe benefits (i.e. health, dental insurance, 401K savings plan, etc.) -- **Attachment A should be completed by the decedent's most recent employer.**

R. If a pension calculation will be involved, please provide a copy of the company's Summary Plan Description (which would detail the formula and normal retirement age), as well as any survivor benefits being received.

S. Educational Attainment (and, in case of child, a verification of class standing via school records preferably). This is mandatory in a case where injured has had no work record or work history is spotty.

T. Summary of Assets -- **Attachment B should be completed by surviving spouse/family members (if there is a claim for loss of net accumulations).**

U. Did the decedent have any pre-morbid medical conditions that would impact his/her remaining life or work-life expectancy such that it/they might well have differed from the statistical average? If so, please provide testimony/information.

II. Loss of Household Services (see Attachment C)

If a claim is being made for the loss of the decedent's services in and around the household, a statement will be required (from the decedent's spouse and/or children), defining and delineating the nature and extent (number of hours per week) of services which the injured party had been providing (see attached). **Attachment C should be completed by surviving spouse/family members (if there is a claim for loss of services.)**

ATTACHMENT A

VALUE OF EMPLOYER FRINGE BENEFIT CONTRIBUTIONS

This form provides information that will be used to determine the value of employer contributions to fringe benefit plans. Please obtain the following information from the decedent's most recent employer and return the completed form to our office.

Decedent (Employee): _____

Employer/Company: _____

Position Held: _____ **Employment Dates:** _____

Base Gross Annual Salary or Wages = $ _____ **(include documentation)***

Additional Bonuses, Commissions, Allowances

Overtime and/or Similar Payments: = $ _____ **(include documentation)***

	Employer/Company Contribution Only: In Dollars (Please specify: Per month, year, etc.)	**OR**	**Employer/Company Contribution Only:** As percent of Gross Annual Base Salary	**Employee Contribution:**
1. Retirement and Savings Contributions:				
a. Defined Benefit Pension Plan	$_____		_____%	$_____
b. 401K Plan	$_____		_____%	$_____
c. Profit Sharing	$_____		_____%	$_____
d. ESOP	$_____		_____%	$_____
e. Other Retirement Plan	$_____		_____%	$_____
2. Medical & Medically Related Benefits:				
a. Hospital, Surgical, Medical	$_____		_____%	$_____
b. Dental	$_____		_____%	$_____
c. Vision	$_____		_____%	$_____
d. **Other (Please Specify)**	$_____		_____%	$_____
3. Miscellaneous Benefit Programs:	$_____		_____%	$_____
4. Other Allowances (please specify): **(i.**e., company-paid allowances for car, phone, etc.)	$_____		_____%	$_____

Information provided by (Name): _____ **Date:** _____

*Please attach supporting documentation, such as W-2 statements, payroll records, earnings statements, employee file, employee benefit statement, employee handbook, pension formula (calculation).

ATTACHMENT B

SUMMARY OF ASSETS

Decedent:_____ **Attorney:** _____

Please provide your best estimates of the value of the decedent's assets at the time of his/her demise.

	Dollar Value
Cash	**$**_____
Savings and Checking Accounts	_____
Stocks	_____
Bonds	_____
Notes or IOUs	_____
Real Estate, Including Family Home, Net of Mortgage(s)	_____
Automobiles	_____
Furnishings/Contents of Home or Apartment	_____
Life Insurance - Cash Surrender Value	_____
Other Assets, Including Antiques, Collections, Tools, Etc.	_____
TOTAL	**$**_____

ATTACHMENT C

LOSS OF HOUSEHOLD SERVICES INFORMATION

Decedent:_____ **Attorney:** _____

This form provides information that will be used to determine the extent (in hours per week) of the loss of household/childcare services occasioned by the above party. Please indicate the amount of time spent on each activity on a per week basis (including weekends). Unless otherwise instructed, we will assume a 50-week year, allowing 2 weeks per year for vacation/rest.

NOTE: THERE IS A *TOTAL OF 168 HOURS IN ONE WEEK*. PLEASE DO NOT INCLUDE TIME FOR OUTSIDE EMPLOYMENT, PERSONAL HYGIENE, RECREATION OR SLEEPING.

	Pre-Incident Hours/Week*
HOUSEHOLD SERVICES:	
1. HOUSEHOLD OPERATIONS (including vacuuming, dusting, clothes laundering, ironing, taking out the trash, shopping for household supplies, clothing, etc.)	
2. COOKING (including grocery shopping, food preparation, clean-up, etc.)	
3. REPAIR AND MAINTENANCE (including home repairs; maintenance, washing, and repairing the household autos and boats; pool maintenance, cleaning, etc.)	
4. LAWN / YARD WORK (including mowing, trimming, raking, watering, etc.)	
5. MANAGEMENT OF HOUSEHOLD ACTIVITIES (including bookkeeping, bill paying, tax preparation, scheduling appointments, etc.)	
TOTAL HOUSEHOLD SERVICES PER WEEK	
CHILDCARE SERVICES (independent of household services):	
Direct childcare services (including supervising household children *independent of other household tasks* (estimated above), bathing, feeding, assisting with homework, chauffeuring, etc.)	
TOTAL CHILDCARE SERVICES PER WEEK	

***If the time indicated is anything other than on a "per week basis" please specify (i.e. daily, monthly, annually).**

Information Obtained From:_____ **Date:** _____