

WAGE LOSS

WRONGFUL DEATH VALUATION FORM

ATTORNEY INFORMATION:

Attorney Name: _____ Date: ____/____/____

Firm: _____

Street: _____

City, State, Zip: _____

Telephone: (____) _____ Facsimile: (____) _____

Email: _____

Case Name: _____

CASE INFORMATION:

Subject's Name: _____

Race (for actuarial purposes only): _____ Gender: M F

Date of Birth: ____/____/____ Date of Death: ____/____/____ Date of Injury: ____/____/____
(if different)

Spouse's Name: _____ Spouse's Date of Birth: ____/____/____

Number of Dependant(s) (not including spouse): _____ Age Dependant(s) leave(s) Household: _____

Dependant(s) Date(s) of Birth: 1) ____/____/____ 2) ____/____/____ 3) ____/____/____ 4) ____/____/____

PRE-DEATH EARNINGS HISTORY:

Job Title: _____

Job Description: _____

Employer: _____

Last Five Years of Income:	Year	Annual Income	# of Months Worked	Employer Paid Fringe Benefits
(Data from W-2s, 1099s, pay stubs, etc.)	_____	\$ _____	_____ months	<input type="checkbox"/> Medical
	_____	\$ _____	_____ months	<input type="checkbox"/> Dental
	_____	\$ _____	_____ months	<input type="checkbox"/> Pension
	_____	\$ _____	_____ months	<input type="checkbox"/> Other
	_____	\$ _____	_____ months	

Please list additional information (job changes and dates, career plans, promotions, etc.) on a separate sheet.

Robert W. Johnson & Associates

4984 El Camino Real • Suite 210 • Los Altos, CA 94022
650/494-2413 • 800/541-7435 • FAX 650/494-2454

Website: www.rwja.com • Email: info@rwja.com

LOSS TO WHOM:

SUBJECT'S NAME: _____

The wrongful death statute applicable in this case requires that the economic loss is:

- Loss to survivor Loss to estate Loss to survivor and estate Other (explain on separate sheet)

FAMILY DATA:

- 1) Should the lost household services be included? Yes No
- 2) Did the spouse work or plan to work? Yes No
- 3) Did the subject's family have any other source of income other than wages? Yes No
- 4) Please describe spouse's income and any employer paid fringe benefits (health insurance, etc.) on a separate sheet. Include costs if known.
- 5) Please describe any non-wage income (interest, rent, etc.) on a separate sheet.

PAYMENT:

- Plaintiff Defense Evaluation needed by: ____/____/____
- Enclosed is a retainer check for \$3,500 payable to **Robert W. Johnson & Associates**. \$ _____
Minimum, retainer for \$3,500 (includes a non-refundable Case Set-Up Fee of \$500 & Expert Designation Fee of \$600 for a total of \$1,100) payable to Robert W. Johnson & Associates. If additional work is required, it will be invoiced at current hourly rates and will be due and payable upon receipt. Payment of all balances is due prior to releasing opinions and/or reports.
- Additional Original Bound Reports: _____ copies @ \$50.00 each..... \$ _____
- Check Total: \$
- Please charge my: MC AMEX VISA Card # _____
- Name as printed on card: _____ Expires: ____/____/____
- Zip code of credit card billing address: _____
- Signature: _____ Date: ____/____/____

AGREEMENT:

The undersigned hereby engages Robert W. Johnson & Associates with respect to the above named case and on the terms and conditions stated above. This contract is made in Los Altos, California on the day and year written below. Should litigation be needed to collect any charges pertaining to this case, Robert W. Johnson & Associates shall be entitled to attorney's fees and all costs of collection in addition to principal and finance charges.

Retaining Attorney's Signature: _____ Date: ____/____/____

All fees and rates are subject to change without notice.

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WRONGFUL DEATH WAGE LOSS
SUPPLEMENTAL INFORMATION NEEDED

- Brief synopsis of case or copy of complaint.
- Income for past 3 to 5 years (W2's, 1099's, Schedule C's, etc.).
- Plaintiff's fringe benefits and the cost of the benefits paid by the employer on behalf of the employee. We are looking for the employer's contribution. Fringe benefits can consist of: medical, dental, vision, life, 401k matching portion, pension, auto allowance, etc.