

**State Bar of Montana**  
**Lawyers' Fund for Client Protection**  
P.O. Box 577, Helena, Mt 59624  
(406)442-7660

**APPLICATION FOR RELIEF**

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**NOTICE TO APPLICANT: In establishing the Lawyers' Fund for Client Protection, (hereafter the "Fund"), the State Bar of Montana did not create, nor acknowledge any legal responsibility for the acts of individual lawyers in the practice of law. All reimbursements of losses to individuals from the Fund shall be a matter of grace and in the sole discretion of the State Bar of Montana, and not as a matter of right. No client or member of the public shall have any right in or to the Fund as a third party beneficiary or otherwise. This disclaimer shall apply both as to the legitimacy of the loss as well as the loss itself.**

1. Full name of applicant: \_\_\_\_\_

2. Address and phone number of applicant: \_\_\_\_\_

\_\_\_\_\_

3. Name of spouse, if joint claim: \_\_\_\_\_

4. Name and address of lawyer whose conduct is alleged to have caused applicant's loss:

\_\_\_\_\_

\_\_\_\_\_

5. Applicant has suffered a loss of money paid to the attorney in the form of a retainer or legal fees in the amount of \$\_\_\_\_\_ by reason of fraudulent or dishonest acts on the part of this attorney, a member of the State Bar of Montana acting as the attorney of applicant, which occurred in the context of the attorney-client relationship.

6. At the time the loss occurred or was discovered, were you the spouse, lineal descendant, or a partner, associate or lawyer-employer or lawyer-employee of this attorney? Yes \_\_\_\_\_ No \_\_\_\_\_

7. The retainer or fees were paid to this attorney on or about what date? \_\_\_\_\_

(Date)

*(Note: Please provide evidence of payment in the form of a receipt, cancelled check, credit card statement or other proof of payment.)*

Date you discovered the loss or theft of funds: \_\_\_\_\_

(Date)

8. Has demand been made on this lawyer? Yes \_\_\_\_\_ No \_\_\_\_\_. If so:

(a) Date of Demand: \_\_\_\_\_

(b) Have you been reimbursed for any part of your claim? Yes \_\_\_\_\_ No \_\_\_\_\_.

If so, state the amount received by you, the person or persons that made the payment and the date of such payment.

\$ _____	_____	_____
Amount	By whom paid	Date

9. State, if known, whether any civil, criminal, or disciplinary proceedings have been or will be taken in connection with the facts set out in this application. If so, state by whom, where and the present status of such proceedings.

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10. Please give as detailed a statement as possible of the nature of the fraudulent or dishonest act(s) complained of, attaching copies of all documents which are in any way related to this claim. (Attach separate sheets if necessary).

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11. Name and address of any lawyer presently representing or assisting you with this application.

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This Application is executed and filed in order to induce the State Bar of Montana to process and investigate it and to consider in its sole discretion the making of payment from the Fund toward indemnification of any loss shown to have been incurred by applicant.

Upon payment by the Fund to the applicant of all or any portion of this claim, the undersigned does hereby transfer, assign and set over to the State Bar of Montana, to the extent of reimbursement made by it, the undersigned's claims, demands, causes of action, actions and suits against said attorney arising out of the above described dishonest acts for which this claim is made. The undersigned authorizes the State Bar of Montana to prosecute such claims, demands, causes of action, actions and suits against said attorney either in the name of the undersigned or in the name of both, as the State Bar in its sole judgment shall deem advisable.

If the amount paid from the Fund to the undersigned applicant is not payment in full for all losses which the undersigned applicant has suffered as a result of the dishonest acts of said attorney for which this assignment is made, then any amounts recovered by the State Bar which remain in its hands after reimbursement to the Fund of the amount paid to the undersigned, together with its costs of collection, shall be paid over to the undersigned.

The undersigned agrees that he/she will cooperate with the State Bar in any efforts by the State Bar in enforcing any claim, demand, cause of action, action or suit against said attorney, and agrees that all civil actions to be taken against said attorney hereunder shall be under the full control of the State Bar, and that the State Bar may as it in its sole judgment deems advisable, prosecute or fail to prosecute, or abandon any such claim, demand, cause of action, action or suit, without the necessity of any consent or approval of the undersigned.

IN CONSIDERATION OF THE FOREGOING, applicant 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 said Fund, applicant agrees to execute and deliver to the State Bar of Montana such instrument or instruments as may be required.

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**AFFIDAVIT**

STATE OF \_\_\_\_\_)

ss.

COUNTY OF \_\_\_\_\_)

I, the undersigned, state that:

I am the Applicant in the above matter; I have read the Lawyers' Fund for Client Protection Rules and the foregoing Application for Relief, and know the contents thereof; and I certify that the same is true of my own knowledge, except as to the matters and things which are therein stated upon my information or belief, and that as to those matters and things, I believe them to be true.

I certify (or declare) under penalty of perjury that the foregoing is true and correct.

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

Executed on \_\_\_\_\_ at \_\_\_\_\_  
(Date) (City) (State)

SIGNED and sworn to (or affirmed) before me, this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_.

(SEAL)

\_\_\_\_\_  
*Signature of Notary*  
Printed Name of Notary: \_\_\_\_\_  
Notary Public for the State of \_\_\_\_\_  
Residing in: \_\_\_\_\_  
My commission expires: \_\_\_\_\_