



Claims Management Unit Claim Form

This form is to help you make your claim

When you have filled in the form, please send it to us at:

Solicitors Regulation Authority
Claims Management Unit
Ipsley Court
Berrington Close
Redditch
Worcestershire
B98 0TD

DX 19114 Redditch

Phone: 01926 487015

Fax: 01926 487062

Email: claims.management@sra.org.uk

www.sra.org.uk



Part 1 – Your information

Mr Mrs Ms Miss Other _____
(Please give details)

Surname or Family name

All other names in full

OR

Organisation name:

Address:

.....Postcode.....

Daytime contact number(s)

E-mail address:

.....

.....

If you have already contacted us, please quote our reference number:

.....

Are you aware of anyone else, or any organisation, who may have a claim or need to know of this claim (for example, a building society, an insurance company, the Legal Services Commission and so on)?

Yes No

If 'Yes', please give details.

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Part 2 – Your claim

Name of the solicitor's firm you are making this claim against:

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Firms address and postcode:

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Are you aware of any money you were owed from the firm? Yes No

If so, how much was it? £.....

Please give the date (or approximate date) on which you first became aware that you may have lost money because of the solicitor's firm.....

What type of work was the solicitor doing for you? Please provide as much information as possible along with any available supporting evidence.

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Have you instructed a new solicitor? If yes, please give name and address below

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If you have instructed a new solicitor to deal with your Compensation Fund claim, please note that we will correspond with them only.

Are you able to claim any part of the loss from another source, for example, insurance?

Yes No

If 'Yes, please give details

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We may need further information or evidence to support your claim. We will let you know if this is the case.

The Solicitors Regulation Authority is committed to the promotion of equality and diversity. As such it will ensure that people can access its service and information. It will make reasonable adjustments where required and appropriate. If you wish to make a request, please contact us on 01926 487015. Our Minicom number is 01926 487020.

Part 3 – Declaration

I confirm that I was a client of this firm and I want to claim any money they may owe me. I understand that if I am not entitled to some or all of the money I receive, I will return it to the Solicitors Regulation Authority within 21 days

I confirm that I have suffered financial loss as a result of a solicitor's dishonesty or failure to pay me money that they received and I am suffering or likely to suffer hardship.

If I receive monies from the Compensation Fund, I acknowledge that you will be entitled to any rights I may have against the solicitor to the extent of any payment made to me. You may sue in my name on the basis that you will protect me against any legal costs. I transfer to you any rights I may have to recover the loss from the solicitor.

I give you permission to gather any information you need from other people and to give other people information about my claim.

As far as I know, the information I have given is true. I acknowledge that I must tell you about any other information (for example, any money I recover or if I am made bankrupt) which may be relevant to this claim.

If I am signing this form as the representative of another person, I confirm that they have authorised me to sign it.

Your name

Your signature: Date:

The signature of the person claiming with you

Your name

Your signature Date:

Customer survey

We want to make sure that we give our customers the service they deserve. To do this, we need to know more about the background of the people we're trying to help, to improve our policies. The information you give will be held and used by the SRA in accordance with the Data Protection Act 1998.

Part A. Sex Please tick ONE of the options below: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say	Part B. Age Please tick ONE of the options below: <input type="checkbox"/> 16-21 <input type="checkbox"/> 51-60 <input type="checkbox"/> 22-30 <input type="checkbox"/> 61-65 <input type="checkbox"/> 31-40 <input type="checkbox"/> 65+ <input type="checkbox"/> 41-50 <input type="checkbox"/> Prefer not to say
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Part C. Ethnicity Please tick ONE of the options below: 1. White <input type="checkbox"/> British English <input type="checkbox"/> Scottish <input type="checkbox"/> Welsh <input type="checkbox"/> Other (please specify) <input type="checkbox"/> Irish <input type="checkbox"/> Roma/Gypsy <input type="checkbox"/> Traveller of Irish Heritage Any other white background (please specify) 2. Mixed <input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian Any other mixed background (please specify)	3. Asian or Asian British <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi Any other Asian background (please specify) 4. Black or Black British <input type="checkbox"/> Caribbean <input type="checkbox"/> African Any other Asian background (please specify) 5. Chinese or other ethnic background <input type="checkbox"/> Chinese Any other ethnic group (please specify) 6. <input type="checkbox"/> Prefer not to say
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Part D. Religion or Belief

Please tick ONE of the options below:

- No religion
- Jewish
- Christian
- Muslim
- Buddhist
- Sikh
- Hindu

Any other religion (please specify

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- Prefer not to say

Part E. Disability

The Disability Discrimination Act 1995 defines a disability as a 'physical or mental impairment which has a substantial and long-term adverse effect on the ability to carry out normal day-to-day activities' (or would have but for any treatment and/or medication). Long-term usually means an impairment which has lasted or is likely to last at least 12 months.

Do you consider yourself to be disabled as defined by the Disability Discrimination Act?

- Yes
- No
- Prefer not to say

If yes, please state the type of impairment that applies to you. People may experience more than one type of impairment, in which case you may tick more than one. If none of the categories apply, please tick other and specify the type of impairment.

- Physical impairment
- Hearing impairment
- Visual impairment
- Learning disability or difficulty
- Mental health condition
- Long-standing illness or health condition
- Other (please specify)

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- Prefer not to say

Part F. Sexual Orientation

Please tick ONE of the options below:

- Lesbian/gay woman
- Heterosexual/straight
- Bisexual
- Gay
- Prefer not to say

Part G. Gender Identity

Please tick ONE of the options below:

Is your gender identity the same as the gender you were assigned at birth?

- Yes
- No
- Prefer not to say