

Form A – Supplement to Application

Claim/Incident Report

Please complete a section for each claim or incident for which you responded YES on your application. Answer in adequate detail to allow proper evaluation. Attach copies of patient's charts, operative notes or other documents as appropriate.

1. Name of patient _____ Age _____ Sex _____

2. ___ Incident ___ Request for records ___ Demand for money or services ___ Suit

3. Date of incident ____/____/____ Date of Notice ____/____/____ Location of incident _____

4. Allegation _____

5. Condition/diagnosis at time of incident _____

6. Dates/description of treatment rendered _____

7. Your insurance carrier _____

8. Other physicians or entities involved _____

9. Disposition of claim:

___ Open Status _____

___ Closed without payment

___ Settlement against ___ plaintiff ___ co-defendant ___ yourself \$ _____

___ Judgment/Verdict against ___ plaintiff ___ co-defendant ___ yourself \$ _____

I understand this information is a part of my Professional Liability Insurance application.

Please type or print name _____

Signature: _____ **Date:** _____