



PROFESSIONAL LIABILITY ASSOCIATION, INC.
RISK RETENTION GROUP, INC.

Professional Liability Claims Information

(Must be printed or typed)

Complete one form for each case. Copies may be made as needed

Insurance Carrier: _____ **Patient Name** _____

Date of Occurrence: _____ **Date of Suit:** _____

Location of Incident: _____

Relationship to Patient (treating Chiropractor, Consultant, etc.)

Primary Defendant: _____ **Co-Defendant:** _____

Patient Outcome: _____

Allegations made about care rendered: _____

Claim Status (Open, Closed, Pending): _____ **Date:** _____

If closed, indicate method of closing: (Circle below)

DISMISSAL

SETTLED

JUDGMENT

CASE-DROPPED

Amount of settlement/judgment: _____ **Date:** _____

Chiropractor (print name): _____ **Date:** _____

I understand that the information submitted here becomes a part of my insurance application and is subject to the same representations and conditions.

Signature of Applicant: _____ **Date:** _____