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 (attending physician, surgeon, 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: ________________

Physician (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: ___________________