

Claims Information Supplemental Application

Physicians & Surgeons Medical Professional Liability Insurance Claims Made & Reported Coverage

Please answer all questions that apply. State "not applicable" to those question that do not apply.

Applicant's Name:

Claimant's Name:

Date of Alleged Incident: Date Claim was made:

Status of Claim: ☐ Dismissed ☐ Abandoned ☐ Won By Defense ☐ Won By Claimant ☐ Open

If "Won By Claimant", answer the following: ☐ Court Judgement ☐ Settlement

Total Paid: \$ Total Paid on You Behalf: \$

If Open, Settlement Demand: \$ Defendant's Settlement Offer: \$

Insurer's Current Loss Reserve: Name of Insurer:

Description of Claim: (Include all services leading up to the claim and any other relevant information.)

I understand all information provided in this document becomes part of my Medical Professional Liability Application for coverage, and as such it is subject to the same conditions and warranty of said application.

Applicant's Signature: _____ Date:

Name of Applicant (Please Print):

Submit the completed form to: