



FORM A (SUPPLEMENT TO APPLICATION): CLAIM / SUIT / INCIDENT REPORT

Please complete this form for each claim, suit and/or incident for which you respond **Yes** on your Application. Answer in adequate detail to allow proper evaluation. Further documentation may be requested by the Underwriting Department.

1. Name of Patient _____ Age _____ Male Female

2. Date of Incident ____/____/____ Location of Incident _____

Insurance Carrier _____ Date Reported to Insurer ____/____/____

Suit Demand for Money Incident Only Notice of Intent to Sue Request for Records

Other _____

3. Summary of condition/diagnosis at time of incident: _____

4. Description of treatment rendered, including dates: _____

5. Allegation: _____

6. Other physicians or entities involved: _____

7. Status/Disposition of Claim:

Closed without indemnity payment Settled Judgment/Verdict (for the defense) Judgment/Verdict (for the plaintiff)

Open—please provide current status and defense strategy: _____

8. Has there been a change in practice as a result of this claim(s)? **Yes** **No** If yes, what has been the change?

I understand this information is part of my Application for Physician/Surgeon Medical Professional Liability Insurance.

Please print your name _____

Signature _____ **Date** ____/____/____