

Please type directly on this form. To activate a checkbox, double click on it and select "Checked."

PHYSICIAN'S NAME:

COVERAGE INFORMATION
SUPPLEMENTAL FORM

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE

A. LIST ALL PREVIOUS PROFESSIONAL LIABILITY INSURERS, DATING BACK 10 years.
LIST CURRENT INSURERS FIRST.

1. INSURER OCCURRENCE
FROM - TO (MM, DD, YYYY)

CLAIMS MADE
FROM - TO (MM, DD, YYYY)

2. INSURER OCCURRENCE
FROM - TO (MM, DD, YYYY)

CLAIMS MADE
FROM - TO (MM, DD, YYYY)

3. INSURER OCCURRENCE
FROM - TO (MM, DD, YYYY)

CLAIMS MADE
FROM - TO (MM, DD, YYYY)

PLEASE EXPLAIN ANY GAPS IN COVERAGE:

If you have previous, pending or dismissed Malpractice cases, please complete following information for each case:

If NOT APPLICABLE, please write none:

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION. ALL FIELDS MUST BE COMPLETED.

A. PATIENT/CLAIMANT INFORMATION:

LAST NAME:

FIRST NAME (FULL):

AGE:

B. DATE OF TREATMENT OR SURGERY THAT LED TO THE ALLEGATIONS AGAINST YOU (MM,YYYY):

C. DATE CLAIM/INCIDENT NOTICE RECEIVED (MM,YYY):

D. HAS THIS CLAIM BEEN REPORTED TO YOUR CURRENT OR FORMER INSURER? YES
 NO

a. IF YES, DATE CLAIM REPORTED TO YOUR CURRENT OR FORMER INSURER (MM,YYYY):
IF YES, PLEASE PROVIDE A COPY OF THE REPORT(S)

E. NAME OF OTHER DOCTOR(S, HOSPITALS, OR HEALTH CARE PROVIDERS, IF ANY, INVOLVED IN THE CLAIM OR SUIT:

F. DISPOSITION OR CURRENT STATUS OF CLAIM OR SUIT. OPEN CLOSED
IF CLOSED, DATE OF CLOSING/SETTLEMENT OR AWARD. (MM, YYYY)

G. INDICATE CASE VALUE ESTABLISHED BY CARRIER, IF KNOWN (IN \$):

H. DEFENDING INSURANCE CARRIER NAME:

I. WAS THIS MATTER CLOSED WITH YOUR CONSENT? YES NO
WAS A CLAIM MADE OR A SUIT FILED? YES NO
WAS PAYMENT MADE? YES NO
IF NO, WAS CLAIM OR SUIT WITHDRAWN? YES NO
IF YES, INDICATE TOTAL AMOUNT OF SETTLEMENT OR AWARD, (IN \$) :

AMOUNT PAID ON YOUR BEHALF (IN \$):

J. NATURE OF ALLEGATIONS IN THE CLAIM OR SUIT:

CONDITION TREATED:

TREATMENT PROVIDED:

ALLEGED NEGLIGENCE:

ALLEGED INJURY:



- K. PLEASE PROVIDE A NARRATIVE DESCRIPTION OF THE MEDICAL FACTS: (MUST INCLUDE, BUT NOT BE LIMITED TO, THE TYPE OF TREATMENT AND/OR SURGERY AND YOUR INVOLVEMENT)