Loss Information Supplement

Please make additional copies if needed.

Applicant's Name _____

Note: Additional documentation may be requested at the Company's discretion.

A. Is the matter related to ☐ A or ☐ B from the Loss Information Section? (Check only one)

B. Patient/Claimant Information:

_____ _____ _____

Last Name **First Name** **Age**

C. Date of treatment and/or surgery, which led, or could lead, to allegations against you: ___ /___ /____
MM DD YYYY

D. Date notice received (if applicable): ___ /___ /____
MM DD YYYY

E. Has this matter been reported to your current or former insurer? ☐ Yes ☐ No

If yes, date reported to your current or former insurer? ___ /___ /____
MM DD YYYY

Current or former insurer name_____

If no, please explain _____

F. Name of all other doctor(s), hospital(s) or healthcare provider(s), if any, involved:

_____

G. Current status: ☐ Open ☐ Closed

If open, indicate dollar value established by insurer: $_____

If closed: 1. Date of closing: ___ /___ /____
MM DD YYYY

2. Was Payment Made? ☐ **Yes** ☐ **No**

a. If yes, did you consent to the settlement? ☐ **Yes** ☐ **No**

b. Total amount of settlement or award: $_____

c. Total amount of settlement or award paid on your behalf: $_____

H. Nature of allegations or potential allegations:

Condition Treated _____

Treatment Provided _____

Alleged Negligence _____

Alleged Injury _____

Please provide narrative description of all relevant facts, including but not limited to your involvement in the treatment and/or surgery:

_____

_____

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