

SUPPLEMENTAL CLAIM INFORMATION

If you indicated that you have been involved in medical malpractice claim(s), please complete this Supplemental Claim Information form for each claim.

GENERAL INFORMATION	Applicant (Defendant's) Name *			
	Claimant (Plaintiff's) Name *			
	Date of Error (mm/yyyy)		Date of Claim (mm/yyyy) *	
	Indicate what has been reported to your insurance carrier *:			
	Name of Insurer			
	Defendant's legal representative			Phone
	Address			
	City		State/Province	Zip/Postal Code
STATUS OF COMPLAINT	Complaint Status *			
	If Court Judgement:	Finding for: _____	Judgement Date (mm/yyyy): _____	Judgement by: _____
	If Out-of-Court Settlement:	Date of Settlement (mm/yyyy): _____		
		Amount Paid on your behalf: \$ _____	Compensation: \$ _____	
		Punitive: \$ _____	Total Settlement: \$ _____	
	If Case Dismissed:	Against You: <input type="checkbox"/>	Against All Defendants: <input type="checkbox"/>	Dismissal Date (mm/yyyy): _____
If Pending:	Claimant's Settlement Demand: \$ _____			
	Claim In Suit:	<input type="radio"/> Yes <input type="radio"/> No	Amount asked in summons: \$ _____	
DESCRIPTION OF CLAIM <i>Provide enough information to allow evaluation</i>	Incident location *			
	Alleged act, error, or omission upon which Claimant bases claim *			
	Description of type and extent of injury or damage allegedly sustained *			
	Patient's Condition at point of your involvement *			
	Patient's Condition at end of treatment *			
	Detailed narration of the case *			