



S U P P L E M E N T A L C L A I M I N F O R M A T I O N

Please supply the following information regarding any instance of claim, suit, or incident which may give rise to a claim whether dismissed, settled out of court, judgment or pending. Answer all questions completely. This form should be photocopied and filled out separately for each claim. Please type or print clearly.

GENERAL INFORMATION	Applicant (Defendant's) Name _____			
	Claimant (Plaintiff's) Name _____			
	Date of alleged error _____		Date of Claim _____	
	Indicate whether <input type="checkbox"/> Claim <input type="checkbox"/> Suit or <input type="checkbox"/> Incident that has been reported to your insurance carrier			
	Name of insurer _____		Agent _____	Phone _____
	Location of court where original complaint was filed _____		Case number _____	
	Defendant's legal representative _____		Phone _____	
	Address _____	City _____	State _____	ZIP Code _____
	Plaintiff's legal representative _____		Phone _____	
	Address _____	City _____	State _____	ZIP Code _____

STATUS OF COMPLAINT	<i>If closed, indicate whether:</i>			
	<input type="checkbox"/> Court judgment	Finding for <input type="checkbox"/> You <input type="checkbox"/> Plaintiff	Date: _____	Determined by <input type="checkbox"/> Judge <input type="checkbox"/> Jury
	<input type="checkbox"/> Out-of-court settlement	Date of settlement: _____	Amount paid on your behalf: \$ _____	Compensation: \$ _____
	<input type="checkbox"/> Case dismissed	<input type="checkbox"/> Against YOU	<input type="checkbox"/> Against ALL DEFENDANTS	Total settlement amount: \$ _____
	<input type="checkbox"/> Case dismissed	<input type="checkbox"/> Against YOU	<input type="checkbox"/> Against ALL DEFENDANTS	Date: _____
	<i>If pending, indicate:</i>			
Claimant's settlement demand: \$ _____	Defendant's offer for settlement: \$ _____	Insurer's loss reserve: \$ _____	Defense reserve: \$ _____	
Claim in suit <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, amount asked in summons: \$ _____	Compensation: \$ _____	Deductible: \$ _____	
		Punitive: \$ _____		

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 _____ -----
	Give a complete narration of the case, relating events in chronological order emphasizing the dates of service and stating in detail what was done each time the patient was seen professionally (treatment and procedures provided). Use reverse side for additional space required. (Please type or print) _____ ----- ----- ----- -----

Printed Name _____ Signature _____

IMPORTANT: In addition to the information above, please attach copies of the complaint, final judgment, settlement & release, or other final disposition of the claim, if available.