USE A SEPARATE FORM FOR EACH CLAIM

CLAIM INFORMATION FORM

Physician's name: Dr. ....

Name of patient: .... Age: .... Sex: ❑ M ❑ F

Please type or print clearly

1. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon): ....
   ....
2. Allegation(s) (as stated by patient/plaintiff): ....
   ....
3. Date of Incident: ....   4. Date Reported to Carrier: ....
5. Location: ....
6. Insurance Carrier(s): ....
7. Other Defendants: ....
8. Present Status: ❑ Incident Only ❑ Pending Suit ❑ Closed

   If Closed: Date Closed: .... Amount Paid: $.....................

   ❑ Settlement ❑ Judgment ❑ Dismissed

   If Open: Reserve Amount: .... Expense Amount: ....

   Status of Claim: ....
9. Details of the claim: ....
   ....
   ....
   ....
   ....
   ....
   ....
   ....

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: .... Date: ....

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