COVERYS®

INSURED'S FIRST NOTICE OF LOSS

INSURED INFORMATION

Name: _____ **Account #:** _____

Employer: _____ **Policy #:** _____

Address: _____ **Policy Period:** _____

_____ **Agent:** _____

_____ _____

Business Phone: _____ **Home Phone:** _____

PATIENT INFORMATION

Name of Patient/Claimant: _____

(First) (MI) (Last)

Address: _____ **Telephone:** _____

_____ **Date of birth:** _____

_____ **SSN:** _____

Has this been previously reported? If so, please provide incident #: _____

Date of Incident (if unknown, give treatment dates): _____

Description of Incident or Treatment: _____

_____

Injuries (if known): _____

_____

THIS IS BEING REPORTED FOR:

- ❑ **Informational purposes only**
- ❑ **Deposition only (please attach)**
- ❑ **Formal claim (claim letter - please attach)**
- ❑ **Medical record request (please attach)**
- ❑ **Formal claim (summons and complaint - please attach)**

DEPOSITION ONLY

Defense Attorney Preference: _____

SUMMONS AND COMPLAINT

Date of Service: _____

Defense Attorney Preference: _____

ADDITIONAL COMMENTS

_____

_____

_____

Report Completed by: _____ **Date:** _____

Please mail or fax this page to:
P.O. Box 55178, 101 Arch Street, Boston, MA 02205-5178, Tel: 800-225-6168, Fax: 617-428-9805

This form is for use by policyholders of Medical Professional Mutual Insurance Company and ProSelect Insurance Company.