ProMutualGroup®

INSURED'S FIRST NOTICE OF LOSS

INSURED INFORMATION

Name: ______________________ Account #: ______________________

Employer: ______________________ Policy #: ______________________

Address: ______________________ Policy Period: ______________________

______________________ Agent: ______________________

Email Address: ______________________

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: ______________________

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Injuries (if known): ______________________

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THIS IS BEING REPORTED FOR:

- ☐ Informational purposes only
- ☐ Deposition only (please submit original)
- ☐ Formal claim (claim letter – please submit original)
- ☐ Medical record request (please submit original)
- ☐ Formal claim (summons and complaint – please submit original)

ADDITIONAL COMMENTS:

Report completed by: ______________________ *Date:* ______________________

Revision date: 06/07