REQUESTED COVERAGE - AMBULATORY SURGERY CENTER APPLICATION

☐ Requesting Professional Liability:

Requested Retro Date: _________

Professional Liability Limits

- $100,000 / $300,000
- $200,000 / $600,000
- $250,000 / $750,000
- $500,000 / $1,500,000

Professional Liability Deductible

- $1,000,000 / $1,000,000
- $1,000,000 / $2,000,000
- $1,000,000 / $3,000,000

☐ Requesting General Liability:

Requested Retro Date: _________ or ☐ Occurrence Based Coverage

General Liability Limits

- $100,000 / $300,000
- $200,000 / $600,000
- $250,000 / $750,000
- $500,000 / $1,500,000

General Liability Deductible

- $1,000,000 / $1,000,000
- $1,000,000 / $2,000,000
- $1,000,000 / $3,000,000

☐ Requesting Employee Benefits Liability (supplement required):

Requested Retro Date: _________

Employee Benefits Liability Limits

- $100,000 / $300,000
- $200,000 / $600,000
- $250,000 / $750,000
- $500,000 / $1,500,000

Employee Benefits Liability Deductible

- $1,000,000 / $1,000,000
- $1,000,000 / $2,000,000
- $1,000,000 / $3,000,000

☐ Requesting Non-Owned Auto Liability (supplement required):

Non-Owned Auto Liability Limits

- $100,000
- $200,000
- $250,000

- $500,000
- $1,000,000

*Requested coverage may or may not be offered please review any quote issued for actual terms and conditions available. Completion of this application neither binds coverage nor guarantees that policy will be issued.
AMBULATORY SURGERY CENTER APPLICATION

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
- If a question is not applicable, then state “N/A”.
- The following information must be submitted with the completed application:
  - Copy of your current professional liability insurance Declarations Page (claims made policies must reflect the retroactive date)
  - Copy of all advertising that you use
  - 5-year company loss runs, valued within the last 60 days

GENERAL INFORMATION

1. Full name of Applicant (Including DBA’s) ______________________________________________________________

2. Mailing Address:

   STREET _______________________________________________________________________________________

   CITY _______________________________________________________________________________________

   COUNTY ____________________________________________________________________________________

   STATE ______________________________________________________________________________________

   ZIP _________________________________________________________________________________________

3. Location Address(es): Check here if same as mailing: □

   (1) _______________________________________________________________________________________

   STREET ____________________________________________________________________________________

   CITY ______________________________________________________________________________________

   COUNTY ___________________________________________________________________________________

   STATE _____________________________________________________________________________________

   ZIP _______________________________________________________________________________________

   (2) _______________________________________________________________________________________

   STREET ____________________________________________________________________________________

   CITY ______________________________________________________________________________________

   COUNTY ___________________________________________________________________________________

   STATE _____________________________________________________________________________________

   ZIP _______________________________________________________________________________________

   (3) _______________________________________________________________________________________

   STREET ____________________________________________________________________________________

   CITY ______________________________________________________________________________________

   COUNTY ___________________________________________________________________________________

   STATE _____________________________________________________________________________________

   ZIP _______________________________________________________________________________________

   (4) _______________________________________________________________________________________

   STREET ____________________________________________________________________________________

   CITY ______________________________________________________________________________________

   COUNTY ___________________________________________________________________________________

   STATE _____________________________________________________________________________________

   ZIP _______________________________________________________________________________________

4. Website Address: www. ____________________________ 5. Telephone: __________________

6. Inspection/Risk Management Contact Name: __________________________

7. Inspection/Risk Management Contact E-mail: __________________________

8. Date Established ________________ Years under current management _____________

9. Applicant is a: □ Individual □ Corporation □ LLC □ Professional Associations □ Partnership □ Joint Venture

   Other: ____________________________
10. Enterprise is:  □ For Profit  □ Not For Profit

11. Is this entity owned by, associated with or controlled by any other entity?   □ Yes  □ No

   If yes, please provide details:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

APPLICANT’S PRACTICE

11. What are the facility days and hours of operation? __________________________

12. Is the applicant accredited by or a member of any professional organization or association?  □ Yes  □ No

   If yes, please name: ____________________________________________

13. Estimated annual gross revenues in the next 12 months?  $____________________

   Annual gross revenues in the past 12 months?  $____________________

14. Does applicant maintain beds for overnight occupancy?  □ Yes  □ No

   If yes, how many? __________. Also attach a copy of license and an explanation including protocols for onsite 24 hour staffing.

15. Please provide number of procedures for the following:

<table>
<thead>
<tr>
<th>TYPE OF PROCEDURE</th>
<th>NUMBER PAST 12 MONTHS</th>
<th>ESTIMATED NUMBER NEXT 12 MONTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortions</td>
<td></td>
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<tr>
<td>Bariatric Surgery</td>
<td></td>
<td></td>
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<tr>
<td>Cosmetic Surgery</td>
<td></td>
<td></td>
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<tr>
<td>Dental/ Oral Surgery</td>
<td></td>
<td></td>
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<tr>
<td>Endoscopy/ Colonoscopy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynecological Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manipulation under Anesthesia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ophthalmology - Cataract</td>
<td></td>
<td></td>
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<tr>
<td>Ophthalmology – Lasik / Refractive</td>
<td></td>
<td></td>
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<tr>
<td>Orthopedic Surgery</td>
<td></td>
<td></td>
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<tr>
<td>Orthopedic Surgery – Including Spine</td>
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<tr>
<td>Otorhinolaryngology with Plastic</td>
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<tr>
<td>Otorhinolaryngology no Plastic</td>
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<td></td>
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<tr>
<td>Pain Management</td>
<td></td>
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<tr>
<td>Plastic/ Reconstructive Surgery</td>
<td></td>
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<tr>
<td>Podiatry</td>
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<tr>
<td>Radiological/ Nuclear/ Chemotherapy</td>
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<tr>
<td>Other: (describe)</td>
<td></td>
<td></td>
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<tr>
<td>Other: (describe)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. Any other services (other than surgery) not listed above? (i.e. Lab, Imaging, Office Visits, etc.)  
   Yes ☐  No ☐  
   If yes, please list type and amount.  
   ___________________________  ___________________________  
   ___________________________  ___________________________  
   ___________________________  ___________________________  

17. **IF ABORTIONS** are indicated please complete the following otherwise skip to question 18.  

<table>
<thead>
<tr>
<th></th>
<th>0-13 Weeks Gestation</th>
<th>13-16 Weeks Gestation</th>
<th>16-20 Weeks Gestation</th>
<th>20+ Weeks Gestation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Surgical Abortions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Medical Abortions</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

   a. Does the applicant perform ultrasounds prior to any abortions?  
      Yes ☐  No ☐  
   b. Please specify method(s) used for both Medical and Surgical Abortions:  
      ____________________________________________________________  
      ____________________________________________________________  
      ____________________________________________________________  

18. **IF BARIATRIC SURGERY** is indicated please complete the following otherwise skip to question 19.  
   a. Please list all procedures and attach protocols for selecting and monitoring patients.  
      ____________________________________________________________  
      ____________________________________________________________  

   b. Is Bariatric surgery **only** performed by American Board Certified General Surgeons? If no, on a separate page please describe which other surgical specialists are performing this procedure and the reasons why they have been granted privileges to perform this procedure.  
      ____________________________________________________________  
      Yes ☐  No ☐  
   c. Is this center a Bariatric Surgery Center of Excellence?  
      ____________________________________________________________  
      Yes ☐  No ☐  

19. **IF PLASTIC OR COSMETIC SURGERY** is indicated please list all cosmetic procedures performed including botox or other injectables otherwise skip to question 20.  
   a. If liposuction (any form or type) is indicated as being performed is it **only** performed by an American Board Certified Plastic Surgeon or General Surgeon? If no, on a separate page please describe which other surgical specialists are performing this procedure and the reasons why they have been granted privileges to perform this procedure.  
      ____________________________________________________________  
      Yes ☐  No ☐  

20. **IF PAIN MANAGEMENT** is indicated please list all Pain Management procedures performed otherwise skip to question 21.
21. Policies and Procedures – Pre-operative:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are written consent forms used for each type of procedure performed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, Is the surgeon also required to sign the consent form?</td>
<td></td>
<td></td>
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<tr>
<td>Is the physician required to discuss the procedure and consent with the patient prior to performing the procedure?</td>
<td></td>
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<tr>
<td>Is there written documentation of a pre-operative anesthesia evaluation and airway assessment per ASA guidelines?</td>
<td></td>
<td></td>
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<tr>
<td>Preoperative history and physical examination in the medical record by the day of surgery?</td>
<td></td>
<td></td>
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<tr>
<td>Is there a formal process in place which includes <strong>pre-operative verification of the patient</strong>?</td>
<td></td>
<td></td>
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<tr>
<td>Is there a formal process in place which includes <strong>pre-operative verification of the surgical site</strong>?</td>
<td></td>
<td></td>
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<tr>
<td>Is there a formal process in place to which includes <strong>marking of the operative site</strong>?</td>
<td></td>
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<tr>
<td>Is there a “time out” immediately before starting the procedure?</td>
<td></td>
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</tr>
</tbody>
</table>

22. Policies and Procedures – Intra and post-operative:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there documentation and signing of all intra-operative orders?</td>
<td></td>
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<tr>
<td>Is there written documentation of all medications and intravenous fluids given?</td>
<td></td>
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<tr>
<td>Are written post-operative instructions provided to all patients?</td>
<td></td>
<td></td>
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<tr>
<td>Is there documentation and signing of all post-operative orders and timely dictation of operative notes?</td>
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<tr>
<td>Is there a formal discharge policy requiring that a patient meet specific criteria prior to being discharged?</td>
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</tbody>
</table>

23. Does the applicant have a preventative maintenance program for all biomedical equipment including anesthesia and critical emergency equipment that includes:
   a. Proper training of all equipment users? Yes | No |
   b. Repairs by qualified personnel? Yes | No |
   c. Documentation of all activities (preventive maintenance, repairs, education)? Yes | No |

24. Anesthesia Delivery and Monitoring:
   a. What is the level of anesthesia provided?
      - Level A – Local or topical anesthesia
      - Level B – Local or topical anesthesia and/or IV or parenteral sedation, regional anesthesia, analgesia or dissociative drugs without the use of endotracheal or laryngeal mask intubation or inhalation general anesthesia
      - Level C – Levels listed above plus and/or surgical procedures with epidural anesthesia, endotracheal or laryngeal mask intubation or inhalation anesthesia, spinal or epidural
   b. Does the applicant permit professionals other than licensed Nurse Anesthetists and Anesthesiologists to administer and/or monitor sedation or general anesthesia? Yes | No |
   c. Are non-Anesthesiologists administering Propofol or deep sedation? Yes | No |

25. Is there a documented protocol for handling in house emergencies? Yes | No |

26. Is there an agreement with a local hospital for emergency transfers? Yes | No |
27. What is the distance from the applicant to the nearest acute care hospital? ____________________________

28. Please provide the name and specialty of the applicant’s Medical Director ____________________________

29. Does the applicant’s Medical Director have direct patient care?  Yes □  No □

30. Is the applicant’s Medical Director □ full-time or □ part-time?

31. Please complete the staff / credentialed provider table below AND provide a staff listing by name for all credentialed physicians:

<table>
<thead>
<tr>
<th>Number Employed?</th>
<th>Number Privileged</th>
<th>Insured Elsewhere?</th>
<th>Coverage Desired?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full Time</td>
<td>Part Time</td>
<td></td>
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<tr>
<td>Full Time</td>
<td>Part Time</td>
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</tbody>
</table>

Physicians: no surgery other than incision of boils and superficial abscesses; suturing of skin or superficial fascia

Anesthesiologists; Pain Management Specialists

Dermatologist; Cardiologists; Gastroenterologist; Proctologists; Ophthalmologists; Urologists, Internists;

General Surgeons; Cardiac Surgeons;

Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery

Thoracic Surgeons; Vascular Surgeons; Neurosurgeons; and Orthopedic Surgeons

Bariatric Surgeons

Podiatrists

Dentists; Oral Surgeons

Nurse Anesthetists

Physicians’ and Surgeons’ Assistants; Nurse Practitioners

Perfusionists

Pharmacists

Chiropractors

RNs, LPNs

X-Ray Technician; Lab Technician

Other (specify):
32. Are all above individuals licensed in accordance with applicable state and federal regulations?  Yes ☐  No ☐

33. Do you require all employed, contracted, or privileged physicians or nurse anesthetists to carry their own professional liability insurance? If yes, what limits are they required to carry?  Yes ☐  No ☐

34. Does the Applicant have a formal credentialing and privileging process which includes primary source verification of professional credentials and privilege qualifications for all surgeons and anesthesia providers? If yes, does it include the following AND attach copy of written credentialing protocols:
   a. Review/approval of requested privileges by the center’s medical director and/or credentials committee?  Yes ☐  No ☐
   b. Continuous updates of new or deleted privileges for ambulatory surgery center staff either through an automated or manual system?  Yes ☐  No ☐

35. Can the Applicant’s staff refuse to schedule a surgery or procedure that is not:
   a. On an individual provider’s list of approved privileges?  Yes ☐  No ☐
   b. Authorized at the Applicant’s surgical center?  Yes ☐  No ☐

36. Do any of the Applicant’s locations have any (explain any “yes” answers on page 8):
   a. Exposure to flammables, explosive, chemicals?  ☐ YES ☐ NO
   b. Catastrophe exposure?  ☐ YES ☐ NO
   c. Exposure to radioactive materials?  ☐ YES ☐ NO

37. Has any claim for General Liability ever been made against any person(s) or entity(ies) proposed for this insurance? If Yes, answer complete a supplemental claims form for each.  ☐ YES ☐ NO

38. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance? If Yes, complete a supplemental claims form for each.  ☐ YES ☐ NO
### Coverage History

39. Please list professional liability insurance carried for each of the past five years.

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Dates Covered</th>
<th>Limits of Liability Per claim/ agg</th>
<th>Deductible</th>
<th>Premium</th>
<th>Retroactive date</th>
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</table>

40. If the applicant is currently insured under a commercial general liability policy please list coverage for the past five years.

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Dates Covered</th>
<th>Limits of Liability Per claim/ agg</th>
<th>Deductible</th>
<th>Premium</th>
<th>Occurrence or Claims – Made?</th>
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</thead>
<tbody>
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</table>

If the current expiring GL policy is claims-made what is the retroactive date? _____________

### Claims and History

41. Has the applicant or any of its employees ever had any professional license or license to prescribe and or dispense narcotics ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **Explain on page 9 or attach additional pages as needed**

42. Has the applicant or any of its employees ever been charged with, or convicted of a crime **other** than minor traffic violations? **Explain on page 9 or attach additional pages as needed**

43. Has the applicant or any of its employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? **Explain on page 9 or attach additional pages as needed**

44. Has any claim or suit for malpractice or professional liability ever been made against the applicant or any other person proposed for this insurance? **How Many? ______** (Complete Supplemental Claims form for Each)

45. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit?  
   If yes, please explain in detail, completing a supplemental claim form for each.

46. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant’s current or prior insurer?  
   If yes, please explain in detail, completing a supplemental claim form for each.
NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto,
commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts. The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion. Completion of this form does not bind coverage. Applicant’s acceptance of the company’s quotation is required prior to binding coverage and policy issuance. All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: ________________________________________  Title: __________________________________________

FEIN #: __________________________________________

Applicants Signature: _______________________________ Date: ________________________________

Agent/Broker Name: __________________________________________
If reporting more than one claim or incident, please photocopy and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient: ____________________________________________ Age: ______ Sex: ______

Incident □  Claim □

Date reported to insurance company: ______________

Name of insurance company: _____________________________________

Date of incident and your treatment: __________________________________

Allegations / Circumstances: ___________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Additional Defendants: _______________________________________________________________________

What is the present condition of the patient? ______________________________________________________
_________________________________________________________________________________________

STATUS OF CLAIM

☐ Suit threatened, no action taken
☐ Suit filed but dropped by claimant
☐ Summary judgment in your favor

Court outcome in YOUR favor:
☐ Jury verdict
☐ Directed verdict

Unresolved/Open
☐ Jury verdict
☐ Directed verdict
☐ Awaiting mediation
☐ Awaiting court action

Reserve amount: $________________

Court outcome in favor of plaintiff:

☐ Jury verdict
☐ Directed verdict

Amount of loss payment: $________________

Name and address of the attorney assigned to your case: ____________________________________________
_________________________________________________________________________________________

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes: ☐ No: ☐

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:
_________________________________________________________________________________________
_________________________________________________________________________________________

_________________________________________________________________________________________

Signature: __________________________________ Date: _______________________
Printed Name: __________________________________