THE MEDICAL PROTECTIVE COMPANY APPLICANT NAME: _____

## MULTI-SPECIALTY HEALTHCARE PROFESSIONAL

### LOSS INFORMATION SUPPLEMENT

**Please complete the following information for each applicant involved in each claim or incident. Please make copies if additional forms are needed for multiple claims or incidents and/or each applicant.**

**Note:** Additional documentation may be requested at The Medical Protective Company's discretion.

**A. Is the matter related to A, B or C from the Loss Information section?** (Check only one.)

- □ **A.** Current or prior claim.
- □ **B.** Complication, incident, or adverse outcome.
- □ **C.** Written request for records.

**B. Is the matter identified in the Loss Information section related to** (Check only one)**:**

- □ Professional Liability
- □ Other Commercial Liability, i.e. General Liability, EPLI, Cyber, etc. (please describe): _____

**C. Patient/Claimant Information:**

_____ _____ _____
Last Name First Name Age

**D. Date of treatment and/or surgery which led, or could lead, to allegations against you:** _____ / _____ (MM/YYYY)

**E. Date of notice received, if applicable:** _____ / _____ (MM/YYYY)

**F. Has this matter been reported to your current or former insurer?** □ Yes □ No

If Yes, date reported to your current or former insurer: _____ / _____ (MM/YYYY)

Current or former insurer name: _____

If No, please explain: _____

**G. Name of all other doctor(s), hospital(s), surgery center(s) or healthcare provider(s), if any, involved:** _____

_____

**H. Current status:** □ Open □ Closed

If open, indicate dollar value established by insurer: $ _____

If closed, date of closing: _____ / _____ (MM/YYYY)

Was a payment made? □ Yes □ No

1. If Yes, did you consent to the settlement? □ Yes □ No
2. Total amount of settlement or award: $ _____
3. Total amount of settlement or award paid on your behalf: $ _____

**I. Nature of allegations or potential allegations:**

Condition treated: _____

Treatment provided: _____

Alleged negligence: _____

Alleged injury: _____

**J. Please provide a narrative description of all relevant facts, including, but not limited to, your involvement in the treatment and/or surgery:**

_____

_____

**K. What steps or procedures have you adopted to prevent a similar claim? Please explain:**

_____

_____

**MANDATORY: ALL DISTRICT OF COLUMBIA APPLICANTS must read the following:**
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.

**MANDATORY: ALL FLORIDA APPLICANTS must read the following:**
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**MANDATORY: ALL MAINE APPLICANTS must read the following:**
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 a denial of insurance benefits.