

**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
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**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 FLORIDA applicants must read and initial 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.



Initial Here