

**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.