

Medical Professional Liability Insurance—Claims-Made Physician Application



ProAssurance Casualty Company • PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • 205.877.4400 • Fax 205.868.4040

With your fully completed, signed and dated application, please submit the following information:

1. Current coverage verification (i.e., declaration page, certificate of insurance).
2. Written verification of the purchase of an extended reporting endorsement (tail) from your present carrier if your current coverage is claims-made and you are not applying for prior acts coverage.
3. Current business letterhead.
4. Current loss runs from prior insurance companies or explanation as to why they are not available.
5. Copy of curriculum vitae (CV).
6. Copy of Continuing Medical Education (CME) Programs completed in the past three years.

Note: Submission of a complete application confers no obligation upon ProAssurance to bind coverage.

1. Personal Information

Name: _____ Degree: _____
FIRST MIDDLE LAST
Social Security Number: _____ Date of Birth: _____ Gender: Male ☐ Female ☐
Email Address: _____
Home Address: _____
City: _____ State: _____ ZIP: _____ Home Phone: _____
Medical License Number(s): State License Number/NPI Number Expiration Date % of Practice

List all State Medical Associations you currently belong to: _____

Please provide additional license information in the space provided at the end of the application.

2. Practice Location

Practice Name: _____ Employment Date: _____/_____/_____
MONTH DAY YEAR
Practice Street Address: _____
City: _____ County: _____ State: _____ ZIP: _____
Office Phone: _____ Office Fax: _____ Website: _____
Mailing Address: _____
Billing Address: _____
Contact Name: _____ Title: _____
Contact Email Address: _____

Please list other practice locations:

Practice Name: _____
Practice Street Address: _____
City: _____ County: _____ State: _____ ZIP: _____
Dates: _____ From: _____ To: _____ % of Practice: _____
Practice Name: _____
Practice Street Address: _____
City: _____ County: _____ State: _____ ZIP: _____
Dates: _____ From: _____ To: _____ % of Practice: _____

Please list additional practice locations in the space provided at the end of the application.

3. Coverage Requested

- A. Requested effective date: _____ / _____ / _____
MONTH DAY YEAR
- B. Please indicate your desired level of coverage.
Primary Coverage Limits (Limit per Claim/Annual Aggregate Limit): _____ / _____
Excess Coverage Limits (where available): _____
- C. Deductible amount (where available): \$ _____
☐ Indemnity Only ☐ Indemnity & Expense ☐ None
- D. Do you desire coverage for a practice entity? Yes ☐ No ☐
If yes, we require a corporation application to be completed.
- E. Will you be carrying additional professional liability insurance with another company? Yes ☐ No ☐

4. Prior Acts Coverage

(Note: Prior Acts Coverage is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by a ProAssurance Company that your request for Prior Acts Coverage has been approved.)

- A. Are you requesting Prior Acts Coverage? If no, please skip to Section 5. Yes ☐ No ☐
Retroactive Date: _____ / _____ / _____
MONTH DAY YEAR
- B. During the period for which you are requesting Prior Acts Coverage, was your practice different in any way from your current practice? (e.g., different states, procedures, coverages, etc.). Yes ☐ No ☐
If yes, please describe the changes in your practice, including all applicable dates in the space provided at the end of the application.

5. Education, Training and Certification

- A. Please list the name and location of all medical schools attended:
- | Institution and Location | Dates Attended | Degree Obtained |
|--------------------------|----------------|-----------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
- B. If your degree was granted from a foreign medical school, are you ECFMG certified? Yes ☐ No ☐
i. Have you ever failed the ECFMG examination? Yes ☐ No ☐
If yes, please explain in the space provided at the end of the application.

- C. Please list all internships, residencies, or fellowships.

Internship

Institution Name: _____

Institution Location: _____

☐ Rotating ☐ Transitional ☐ Straight (Specialty: _____)

Dates Attended: From: _____ To: _____
MM/DD/YY MM/DD/YY

Did you successfully complete this program? Yes ☐ No ☐

If no, please explain in the space provided at the end of the application.

Residency

Institution Name: _____

Institution Location: _____

Specialty/Department: _____ Dates Attended: From: _____ To: _____
MM/DD/YY MM/DD/YY

Did you successfully complete this program? Yes ☐ No ☐

If no, please explain in the space provided at the end of the application.

Fellowship

Institution Name: _____

Institution Location: _____

Type of Fellowship: _____ Dates Attended: From: _____ To: _____
MM/DD/YY MM/DD/YY

Did you successfully complete this program?

Yes ☐ No ☐

If no, please explain in the space provided at the end of the application.

☐ Please indicate here if you attended more than one medical/professional school or participated in additional programs to those listed above and include information in the space provided at the end of the application.

D. Are you board certified?

Yes ☐ No ☐

i. If yes, please indicate which board and specialty/subspecialty:

☐ American Board of _____

☐ American Osteopathic Board of _____

ii. If not boarded, when do you plan to take your boards? _____

iii. Are you required to recertify?

Yes ☐ No ☐

If yes, please provide date of recertification: _____

iv. Have you ever failed a board certification or recertification examination?

Yes ☐ No ☐

If yes, how many times? _____ (Oral) _____ (Written)

E. Please indicate your current life support certification information:

☐ ACLS Certified ☐ BCLS Certified ☐ ATLS Certified ☐ PALS Certified

6. Practice Information

A. What is your present specialty? _____ % of Practice: _____

B. What is your present sub-specialty? _____ % of Practice: _____

C. Have there been any changes in your specialty, procedures, or practice activity within the past five years?

Yes ☐ No ☐

If yes, please describe in the space provided at the end of the application.

D. How many patients do you see on average per week? _____

E. How many hours do you practice on average per week? _____

(Practice hours include hospital rounds, charting, consultation with other physicians, patient visits/consultations, paramedical supervision, and on-call hours involving patient contact, whether direct or by telephone.)

F. Do you practice any of the following?

☐ Ayurvedic Medicine

☐ Chinese Medicine (including Acupuncture)

☐ Holistic Medicine

☐ Homeopathic Medicine

☐ Naturopathic Medicine

G. Do you perform medical or surgical procedures in an office-based surgical suite?

Yes ☐ No ☐

H. Do you provide medical professional services (including opinions or advice) via the internet or any telemedicine program?

Yes ☐ No ☐

If yes, what percentage of your practice does this constitute? _____%

i. Do you provide these services to patients in states outside your primary practice location?

Yes ☐ No ☐

If yes, please provide a list of states: _____

I. Do you provide services to any nursing home or similar facility?

Yes ☐ No ☐

If yes, what percentage of your practice do these services constitute? _____%

Please list the name of the facility(ies): _____

J. Do you provide services to any local, state, or federal correctional facility?

Yes ☐ No ☐

If yes, what percentage of your practice do these services constitute? _____%

Please list the name of the facility(ies): _____

K. Do you, or will you, staff an emergency department?

Yes ☐ No ☐

If yes, is the emergency department work required to maintain hospital staff privileges?

Yes ☐ No ☐

i. How many hours per month do you practice in the emergency department? _____

- L. Do you have an agreement/contract to provide care at:
- ☐ Nursing Home
- ☐ Correctional Facility
- ☐ Emergency Department
- M. Are you a sports team physician for any high school, college, university, semi-professional or professional team? Yes ☐ No ☐
- If yes, provide the name of the institution or team: _____
- N. Do you or your employees provide home health or mobile health care services? Yes ☐ No ☐
- If yes, please explain in the space provided at the end of the application.
- O. Do you serve as a Medical Director? Yes ☐ No ☐
- If yes, please list the name of the facility(ies): _____
- i. Is professional liability insurance provided by the facility for your duties as Medical Director? Yes ☐ No ☐
- If yes, please provide proof of coverage.
- P. Have you participated in a clinical trial within the last ten years? Yes ☐ No ☐
- If yes, please provide details in the space provided at the end of the application.
- Q. Are you employed full-time or part-time by the Federal, State, or Local Government? Yes ☐ No ☐
- If yes, please provide the nature of such employment in the space provided at the end of the application.
- R. Are you on active duty in the U.S. Military Service? Yes ☐ No ☐

S. Procedures

- i. Please review *each* section for any procedures that apply to your practice. This information is used for rating purposes; the procedures are not grouped by rating classification.

Anesthesia, Physical Medicine, Rehabilitation/Pain Management Procedures

- ☐ Anesthesia (check type and where administered)

	<u>Hospital</u>	<u>Surgical Suite</u>	<u>Office</u>
<input type="checkbox"/> Caudal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Moderate (Conscious) Sedation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> General	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- ☐ Lumbar Puncture

- ☐ Pain Management

- | | |
|------------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Medication Only | <input type="checkbox"/> Thoracic Sympathectomies |
| <input type="checkbox"/> Spinal Cord Stimulators | <input type="checkbox"/> Implantation/Removal of Drug Infused Pumps |
| <input type="checkbox"/> Facet Blocks | <input type="checkbox"/> Sphenopalatine Lesioning |
| <input type="checkbox"/> Selective Nerve Root Blocks | <input type="checkbox"/> Trigeminal Lesioning |
| <input type="checkbox"/> Rhizotomy | <input type="checkbox"/> Cordotomies |
| <input type="checkbox"/> Spinal Injections | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dorsal Root Gangliotomies | |

- ☐ Trigger Point Injections

Radiology Related Procedures

- | | |
|--------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Fluoroscopy | <input type="checkbox"/> Radiology – Interventional |
| <input type="checkbox"/> Mammography | <input type="checkbox"/> Radiation/X-ray Therapy |
| <input type="checkbox"/> Myelography | <input type="checkbox"/> Radiopaque Dye |

Cosmetic/Dermatological Procedures

- | | |
|---------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Laser Hair Removal |
| <input type="checkbox"/> Botox Injections | <input type="checkbox"/> Laser Skin Resurfacing |
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Laser Vein |
| <input type="checkbox"/> Chemabrasion | <input type="checkbox"/> Lipodissolve/Mesotherapy |
| <input type="checkbox"/> Collagen Injections | <input type="checkbox"/> Liposuction |
| <input type="checkbox"/> Cryosurgery (superficial only) | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Dermabrasion | <input type="checkbox"/> Sclerotherapy |
| <input type="checkbox"/> Dermatopathology (diagnostic) | <input type="checkbox"/> Silicone Injections |
| <input type="checkbox"/> Fat Transfer | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hair Transplants | |

Surgical (Invasive) Procedures

- ☐ Angioplasty
☐ Assist in surgery
 ☐ On Own Patients
 ☐ On Patients of Others
☐ Bariatric Surgery
☐ Bronchoscopy
☐ Cardiac Surgery
☐ Cholecystectomy
☐ Circumcision (other than newborns)
☐ Colonoscopy
☐ Colposcopy
☐ Cryosurgery (other than external lesions)
☐ D&C
☐ Endoscopic Laser Therapy
☐ Endoscopy other than Proctoscopy, Sigmoidoscopy, Colposcopy, and Cystoscopy
☐ ERCP/EGD/ERC
☐ Fracture Reductions
 ☐ Open
 ☐ Closed
☐ Hand Surgery
☐ Head and Neck Surgery
☐ Hemorrhoidectomy
☐ Hernia Repair
☐ Hyperbaric Medicine/Wound Care

- ☐ Hysterectomy
☐ Hysteroscopy
☐ Left Heart Catheterization
☐ Obstetrics/Gynecology – Major Surgery
☐ Vaginal Deliveries Number Per Year: _____
☐ C-Sections Number Per Year: _____
☐ VBAC Number Per Year: _____
☐ Ophthalmology Surgery
☐ Orthopedic – Major Surgery
☐ Spines
☐ No Spines
☐ Otorhinolaryngology – Major Surgery
☐ Including Elective Cosmetic Procedures
☐ Penile Implants
☐ Permanent Pacemaker
☐ Plastic – Major Surgery
☐ Robotic Surgery
☐ Roux-en-y (non-bariatric)
☐ Thoracic Surgery: _____% of Practice
☐ Tonsillectomy/Adenoidectomy
☐ Tubal Ligation
☐ Transgender Surgery
☐ Trauma Surgery
☐ Vascular Surgery: _____% of Practice
☐ Vasectomy

Other Procedures

- ☐ Abortions
☐ Angiography/Arteriography
☐ Breast Biopsy
☐ Chelation Therapy
 (for other than heavy metal poisoning)
☐ Echocardiography
☐ ECT (Shock Therapy)
☐ Fertility Treatment
☐ Hormonal Gender Conversion
 (other than genetic)

- ☐ Independent Medical Exams: _____% of Practice
☐ Lithotripsy
☐ Neonatology
☐ Percutaneous Vertebroplasty
☐ Prenatal Care
☐ Prolotherapy
☐ Weight Control: _____% of Practice
 Medications Prescribed (please list): _____

ii. If none of the above procedures apply to your practice, please initial here: _____

iii. Do you perform procedures that are outside the customary scope of practice within your specialty?

Yes ☐ No ☐

If yes, please list procedures: _____

iv. Do you perform any diagnostic or therapeutic procedures which have been introduced to the medical profession within the past two (2) years?

Yes ☐ No ☐

If yes, please provide the name of the procedures in the space provided at the end of the application.

7. Information on Paramedical Employees

Any person licensed, certified, or otherwise authorized to deliver advanced level health care in the absence of direct supervision by a licensed physician is considered a Paramedical, including the following:*

- | | |
|--------------------------------------|----------------------------|
| - Anesthesiologist Assistant | - Optometrist |
| - Certified Nurse Anesthetist (CRNA) | - Perfusionist |
| - Certified Nurse Practitioner (CNP) | - Physician Assistant (PA) |
| - Cytotechnologist | - Psychologist |
| - Emergency Medical Technician (EMT) | - Surgical Assistant (SA) |
| - Nurse Midwife | |

A. Do you supervise paramedical employees as defined above who are under your employ?

Yes ☐ No ☐

B. Do you or any member of your group currently supervise paramedical employees as defined above who are not in your employ?

Yes ☐ No ☐

***Any paramedical desiring coverage must submit a paramedical application. A separate charge may apply.**

Coverage may not be available in all states.

8. Hospital Affiliations and Privileges

A. Please list all hospitals where you have active privileges or a pending application.

Hospital Name: _____	Percentage of your patients admitted into this facility: _____%
Location: _____	Privileges: Active <input type="checkbox"/> Pending <input type="checkbox"/>
Department: _____	Start Date: _____/_____/_____ MONTH YEAR MONTH YEAR
End Date: _____/_____ MONTH YEAR	
Hospital Name: _____	Percentage of your patients admitted into this facility: _____%
Location: _____	Privileges: Active <input type="checkbox"/> Pending <input type="checkbox"/>
Department: _____	Start Date: _____/_____/_____ MONTH YEAR MONTH YEAR
End Date: _____/_____ MONTH YEAR	
Hospital Name: _____	Percentage of your patients admitted into this facility: _____%
Location: _____	Privileges: Active <input type="checkbox"/> Pending <input type="checkbox"/>
Department: _____	Start Date: _____/_____/_____ MONTH YEAR MONTH YEAR
End Date: _____/_____ MONTH YEAR	
Hospital Name: _____	Percentage of your patients admitted into this facility: _____%
Location: _____	Privileges: Active <input type="checkbox"/> Pending <input type="checkbox"/>
Department: _____	Start Date: _____/_____/_____ MONTH YEAR MONTH YEAR
End Date: _____/_____ MONTH YEAR	

B. Has any group or hospital suspended, restricted or refused your staff privileges, or have you ever voluntarily surrendered or limited your privileges?

Yes ☐ No ☐

If yes, please describe in the space provided at the end of the application.

9. Professional Liability Insurance and Claims History

A. List current and former professional liability information. (Please provide a minimum ten-year history.)

Name of Insurance Company (current): _____	
Practice/Employer: _____	Location: _____
Policy Type: Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>	Policy Limits: _____
Dates Covered: From: _____ To: _____	If Claims-Made, Retro Date: _____/_____/_____ MONTH DAY YEAR
Did you purchase/receive a reporting endorsement (tail coverage)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Name of Insurance Company: _____	
Practice/Employer: _____	Location: _____
Policy Type: Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>	Policy Limits: _____
Dates Covered: From: _____ To: _____	If Claims-Made, Retro Date: _____/_____/_____ MONTH DAY YEAR
Did you purchase/receive a reporting endorsement (tail coverage)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Name of Insurance Company: _____	
Practice/Employer: _____	Location: _____
Policy Type: Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>	Policy Limits: _____
Dates Covered: From: _____ To: _____	If Claims-Made, Retro Date: _____/_____/_____ MONTH DAY YEAR
Did you purchase/receive a reporting endorsement (tail coverage)?	Yes <input type="checkbox"/> No <input type="checkbox"/>

B. Has any insurance company, including Lloyd's of London, that offered you medical professional liability or related coverage ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions?

Yes ☐ No ☐

If you answer yes to this question, provide complete details in the space provided at the end of the application or on a separate sheet.

C. Have you ever been involved in a medical professional liability claim or suit? The word "claim" as used in this question refers to any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee, or professional corporation or partnership.

Yes ☐ No ☐

- D. Other than the situations indicated in 9.C. above, are you aware of any of the following circumstances:
- i. A request for records from a patient, family member, attorney, or patient representative related to an adverse outcome or treatment of a patient? Yes ☐ No ☐
 - ii. A letter from an attorney regarding your treatment of a patient? Yes ☐ No ☐
 - iii. A patient, family member, or patient representative's dissatisfaction with the outcome of a procedure, treatment, or diagnosis? Yes ☐ No ☐
 - iv. Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit? Yes ☐ No ☐
- E. Have all circumstances in question 9.D. above been reported to your current or prior professional liability carrier? Yes ☐ No ☐ N/A* ☐
- If yes, how many? _____ Please attach documentation of all such reports.
- If no, please explain in space provided at the end of the application.
- *For purposes of this question, N/A means that you answered "No" to each subpart of question 9.D.

10. Personal History

- If you answer yes to any of the following questions, provide complete details in the section at the end of the application or on a separate sheet.
- A. Has your license to practice medicine or your permit to prescribe drugs *ever* been denied, revoked, suspended, voluntarily suspended, or otherwise investigated or limited in any way? Yes ☐ No ☐
 - B. Have you *ever* appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee? Yes ☐ No ☐
 - C. Have you *ever* had a patient, patient's family member, or patient representative complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee? Yes ☐ No ☐
 - D. Have you *ever* been convicted of, pled guilty to, pled no contest to, or entered into a plea agreement for a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol or any other substance? Yes ☐ No ☐
 - E. Have you *ever* been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any mental illness that could be considered to impact your ability to practice, including but not limited to depression and/or chronic fatigue? Yes ☐ No ☐
 - F. Have you *ever* been accused of sexual misconduct of any kind? Yes ☐ No ☐
 - G. Do you have any physical handicap or chronic illness that could be considered to impair your ability to practice? Yes ☐ No ☐
 - H. Has your membership in any professional association or society ever been revoked or refused? Yes ☐ No ☐

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Consent to Conditions of Consideration of the Application for Insurance

I understand that no coverage will be bound until after ProAssurance has reviewed my completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression by ProAssurance of intent to provide coverage. If ProAssurance declines to offer coverage, my advance payment will be promptly returned to me.

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me.

Without waiving any substantive rights and remedies provided under applicable statutes and regulations, to the fullest extent permitted by law, I release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I understand that should any incident, injury or death occur to any patient while under my care subsequent to my signing and dating this application, I must notify ProAssurance or its authorized agent or broker in writing of such event.

Name (Printed): _____

Applicant's Signature: _____ Date: _____

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Applicant's Representation and Authorization which requires your signature. Please read it carefully.

Applicant's Representation and Authorization

I, the undersigned, hereby authorize my present and prior professional liability carriers, any and all attorneys who have represented me in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding me, to release to ProAssurance, upon its request, any information which in the judgment of any such person noted above may have bearing upon my acceptability to ProAssurance and its subsidiaries as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

I understand that third-party information, records or data regarding my practices, medical procedures and/or prescribing practices may be used for informational or underwriting purposes.

I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions or mistakes contained in such released information.

I further agree that ProAssurance and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the signed original.

I hereby declare and represent that the foregoing statements and particulars are complete, to the best of my knowledge and recollection, and that I have not willfully concealed, omitted, or misrepresented any material fact or circumstance concerning this insurance or the subject thereof.

Name (Printed): _____

Applicant's Signature: _____ Date: _____

Note: ProAssurance's Privacy Policy can be found on ProAssurance.com.

For Agent's Use Only (if applicable)	
Agent's Name and License Number	Agency Name
Signature	Agency Address
Date	Phone

Additional Comments

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.

Please attach additional sheets as necessary.

Physician's Supplementary Claims Information Form

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed.

All questions must be answered or marked Not Applicable (N/A).

1. Patient's Name: _____
2. Date Reported to Insurance Company: _____
3. Name of Insurance Company: _____
4. Name and Address of the Attorney Assigned to Your Case: _____
5. Date of Incident and Your Treatment: _____
6. Allegations: _____

7. What is the present condition of the patient? _____

8. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes ☐ No ☐
9. Status of claim (check applicable answer):

<input type="checkbox"/> Suit threatened, no action taken <input type="checkbox"/> Suit filed, but dropped by claimant <input type="checkbox"/> Summary Judgment in your favor <input type="checkbox"/> Suit settled Out-of-Court Date claim paid: _____ Amount paid: _____	<input type="checkbox"/> Court outcome in your favor <input type="checkbox"/> Jury verdict <input type="checkbox"/> Directed verdict <input type="checkbox"/> Court outcome in favor of plaintiff <input type="checkbox"/> Jury verdict <input type="checkbox"/> Directed verdict Amount of Loss: _____	<input type="checkbox"/> Awaiting mediation <input type="checkbox"/> Awaiting court action Reserve Amount: _____
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------
10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes ☐ No ☐
If yes, amount was: \$ _____

Name (Printed): _____

Signature: _____ Date: _____