Positive Physicians Insurance Company

Loss Information Supplement

Please make copies if additional forms are needed.

Applicant's Name: _____

Note: Additional documentation may be requested at Positive Physicians Insurance Company discretion.

A. Is the matter related to: **A** ☐ **B** ☐ **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. Patient/Claimant Information:

Last Name _____ First Name _____ Age ____

C. Date of treatment and/or surgery which led, or could lead, to allegations against you. ____ / ____ (MM / YYYY)

D. Date of notice received, if applicable. ____ / ____ (MM / YYYY)

E. 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: _____

F. Name of all other doctor(s), hospital(s), or health care provider(s), if any, involved. _____

G. Current status: ☐ Open ☐ Closed

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

If closed:

1. Date of closing: ____ / ____ (MM / YYYY)
2. Was a payment made? ☐ Yes ☐ No
   a. If yes, did you consent to the settlement? ☐ Yes ☐ No
   b. Total amount of settlement or award: $ _____
   c. Total amount of settlement or award paid on your behalf: $ _____

H. Nature of allegations or potential allegations:

Condition Treated: _____

Treatment Provided: _____

Alleged Negligence: _____

Alleged Injury: _____

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

_____

_____

_____

_____

_____

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