# Premium Indication Request for Non-Standard Physicians

Please read carefully before completing:

**This is a premium indication request only. It is not an application for medical malpractice insurance coverage and does not, in any way, bind coverage. The information contained in this request will be used to acquire premium indications from one or more insurance carriers as appropriate and will otherwise be held in the strictest confidence.**

**SIGNATURE**

After completing the premium indication request, the applicant's signature is required, along with the date. Please complete the request completely.

**CLAIMS INFORMATION**

If you have any claims, suits, or incidents alleging malpractice brought against you within the past ten (10) years, complete a claim information sheet for each claim. Each Claim Information Sheet must be completed, signed and dated.

**RETROACTIVE ("NOSE") COVERAGE**

If you wish to obtain nose coverage, a copy of your most recent declarations page from your current carrier indicating the original effective date of coverage and a current paid through date must be attached.

**Tegner-Miller Insurance Brokers - CAMM**
**2001 Wilshire Boulevard Suite 101**
**Santa Monica, CA 90403**
**Phone: 800.775.8642**
**Fax: 310.453.7971**
**E-mail: insure@tmib.com**

## I. Personal Information

1. Entity Name as Named Insured _____

   Office Street Address _____

   City, County, State, Zip _____

2. Your Full Legal Name – Individual _____

   Mailing Street Address *(if different from office address)* _____

   City, County, State, Zip _____

3. Effective Date Desired _____ Retroactive Date Desired _____

4. Date of Birth _____ Place of Birth _____

   Social Security or I.R.S. No. _____

   Residence Street Address _____

   Residence Telephone No. _____

5. Desired Limits of Liability:
   - ☐ $1,000,000 per claim/$3,000,000 annual aggregate
   - ☐ $2,000,000 per claim/$4,000,000 annual aggregate
   - ☐ $5,000,000 per claim/$5,000,000 annual aggregate
   - ☐ Other

6. Medical Specialty _____

7. a. Are you American Board Certified in your specialty? ☐ Yes ☐ No

   b. Name(s) of American Specialty Board(s) _____

   _____

8. a. Are you licensed by the state in which you now practice? ☐ Yes ☐ No

   Federal DEA No. _____

   License No. _____ ☐ Permanent ☐ Temporary

   b. Are you licensed in any other state? ☐ Yes ☐ No

   ***If yes, please identify State and License No. on the Comments page.***

   Taxpayer Identification Number _____

## II. Underwriting Information

9. If you use a collecting agency, does the agency have the authority to file a collection suit at its discretion? ☐ Yes ☐ No

10. Has any medical professional liability insurer cancelled, declined coverage, refused renewal, or renewed your coverage under restrictive conditions? ☐ Yes ☐ No
***If yes, please explain on Comments page.***

11. Have you ever used any intoxicant, narcotic, or psychoactive drug to the extent that it has interfered with your ability to perform professional duties? ☐ Yes ☐ No
***If yes, please explain on Comments page.***

12. Do you have any physical or mental problems which might affect your practice of medicine? ☐ Yes ☐ No
***If yes, please explain on Comments page.***

13. Have you ever been convicted of a felony? ☐ Yes ☐ No

14. Has any investigation, revocation, suspension, restriction, other disciplinary action, or other change in status occurred with respect to your license to practice, your DEA license, your privileges or participation at any hospital, health maintenance organization, or other medical facility, or your certification by or membership in any medical association, medical society, or medical board? ☐ Yes ☐ No

15. Has a fee complaint or professional conduct complaint ever been registered against you with your medical association or state or county medical society, State Board of Medical Examiners, or hospital medical staff? ☐ Yes ☐ No

***If yes, please provide a copy of the complaint, your answer, and, if resolved, the final resolution from your Medical Board. For professional conduct complaints, also submit copies of the patient charts and operative notes if these documents are a matter of public record.***

## III. Claim, Incident, and Insurance History

16. a. Have you ever been involved in a malpractice claim, suit, or "incident" either directly or indirectly? ☐ Yes ☐ No

b. Are you aware of any facts or circumstances which may give rise to a claim or suit in the future? ☐ Yes ☐ No

***If you responded "yes" to either of the above, please complete a Supplemental Claims Information form for each circumstance. For more than one incident or claim, please use photocopies of the form.***

17. List the names of all professional liability insurance carriers which have insured you during the past five years and the dates of such coverage. ***Continue on the Comments page, if necessary.***

a. Carrier: _____ Inception Date: _____ Expiration Date _____

If a Claims-Made policy, provide policy retroactive date _____ Policy Number: _____

b. Carrier _____ Inception Date _____ Expiration Date _____

If a Claims-Made policy, provide policy retroactive date _____ Policy Number: _____

c. Carrier _____ Inception Date _____ Expiration Date _____

If a Claims-Made policy, provide policy retroactive date _____ Policy Number: _____

***Attach a copy of the Declarations Page(s) from your current policy.***

18. If your coverage is currently Claims-Made, do you wish to buy prior acts coverage from American Healthcare Indemnity Company to insure you for new, unreported claims arising from services you provided while you were insured with your present carrier? ☐ Yes ☐ No

a. If no, do you intend to purchase extended reporting endorsement ("tail") coverage from your present carrier? ☐ Yes ☐ No

***Submit a copy of your extended reporting endorsement, if applicable.***

## IV. Medical Information

19. **Medical School:**

_____
*School* *City* State

Country: _____ Year Graduated:_____ Degree: _____

**Internship:**

_____ From: _____ To:_____
*Hospital* *City* *State* *mo/yr* *mo/yr*

**Residency:**

_____ From: _____ To:_____
*Hospital* *Specialty* *City* *State* *mo/yr* *mo/yr*

_____ From: _____ To:_____
*Hospital* *Specialty* *City* *State* *mo/yr* *mo/yr*

**Fellowship in: _____:**
*Subspecialty*

_____ From: _____ To:_____
*Hospital* *City* *State* *mo/yr* *mo/yr*

20. Have you met all the legal requirements in your state for continuing medical education? **.....** ☐ Yes ☐ No

***On the Comments page, please list all courses taken in the last 12 months, including dates and number of CME credits; any additional training; where, dates and type of training. List postgraduate studies and specialty society meetings.***

## V. Your Practice

21. List all locations where you have practice for the last 10 years. Of the locations where you now practice, also indicate the average number of hours you practice at each location. ***Continue on Comments page, if necessary.***

a. Address: _____

County: _____ From:_____ To: _____ Hours per week:_____

b. Address: _____

County: _____ From:_____ To: _____ Hours per week:_____

c. Address: _____

County: _____ From:_____ To: _____ Hours per week:_____

22. List hospitals at which you currently are or have been a staff member. ***List additional hospitals on the Comments page.***

a. Hospital: _____

Address: _____

County: _____ Type of privileges (active, courtesy, etc.):_____

From:_____ To: _____
*mo/yr* *mo/yr*

b. Hospital: _____

Address: _____

County: _____ Type of privileges (active, courtesy, etc.):_____

From:_____ To: _____
*mo/yr* *mo/yr*

23. Are you employed by any corporate or fictitious name entity? (i.e. DBA) ***Please provide name*** ☐ Yes ☐ No

_____

24. Do you own shares in a professional corporation? ***Please provide names of all other shareholders*** ☐ Yes ☐ No

_____

_____

25. Do you have any partners? ***Please provide names and insurance carriers*** ☐ Yes ☐ No

_____

26. Do you employ any physicians, surgeons, podiatrists, or chiropractors? ☐ Yes ☐ No

***Please provide names and insurance carriers.***

_____

_____

27. Are you employed by any physicians or surgeons? ***Please provide names and insurance carriers*** ☐ Yes ☐ No

_____

_____

28. Do you have any associates? ***Please provide names and insurance carriers*** ☐ Yes ☐ No

_____

Indicate the extent of your association. *(Please check one)*

☐ Share Office
☐ Common Billings
☐ Share Employees
☐ Independent Contractor
☐ Share Calls
☐ Other (Specify below)

_____

29. ***Please attach a copy of your office letterhead.***

30. Do you advertise (*other than a general yellow pages listing*)? ☐ Yes ☐ No
***If yes, submit copies of print, audio (i.e. radio), and video (i.e. television) advertising currently used.***

31. On ***average***, how many hours per day and days per week do you practice?

a. Hours per day? _____

b. Days per week? _____

Of the above, how many hours per day/days per week are devoted to *direct patient care*?

1. Hours per day? _____
2. Days per week? _____

Of the above, how many hours per day/days per week are devoted to *related administrative activities*?

1. Hours per day? _____
2. Days per week? _____

32. What is your average weekly patient load? _____

a. Of this number, how many require surgery by you? _____

b. What percentage of your patients are treated under capitated agreements? _____ %

33. Do you employ any Physician Assistants? Nurse Practitioners? ☐ Yes ☐ No

***Please submit evidence of approval by the State Licensing Board for the Physician's Assistant(s) and the supervising physician.***

34. Do you employ any Nurses? ☐ Yes ☐ No

a. Number of nurses employed?_____

b. List number and professional classification of any other assistants you employ:

No. _____ Class_____

No. _____ Class_____

No. _____ Class_____

No. _____ Class_____

No. _____ Class_____

No. _____ Class_____

No. _____ Class_____

## VI. Procedures

35. Do you perform abortions? ☐ Yes ☐ No

***If yes:*** a. Number performed monthly on your own patients _____

b. Number performed monthly on referral patients _____

c. From whom do you receive referrals? _____

d. List hospitals, clinics, or other facilities where you perform abortions:

1._____

2._____

3._____

4._____

5._____

e. Describe methods used:

_____

_____

36. Do you administer anesthesia? ☐ Yes ☐ No

a. Spinal? ☐ Yes ☐ No

b. Caudal? ☐ Yes ☐ No

c. General? ☐ Yes ☐ No

d. Intravenous? ☐ Yes ☐ No

e. Local? ☐ Yes ☐ No

f. In a non-hospital facility? ☐ Yes ☐ No

g. Other? ☐ Yes ☐ No

Describe methods used:

_____

_____

37. Do you practice weight reduction or control? ☐ Yes ☐ No
    a. Do you solicit or advertise for weight control patients? ☐ Yes ☐ No
    b. Do you receive referral patients from weight control clinics? ☐ Yes ☐ No
    c. What percentage of your patients are involved exclusively in weight control? _____ %
    d. Do you use: 1. Injections for weight control? ☐ Yes ☐ No
       2. Drugs for weight control? ☐ Yes ☐ No
    e. Do you dispense (as opposed to prescribe) any weight control drugs? ☐ Yes ☐ No

    ***If yes, please list all drugs dispensed and types of injections used for weight control.***

    _____

    _____

38. Do you perform surgery for obesity? ***If yes, please describe procedures performed on the Comments page*** ☐ Yes ☐ No

39. Do you perform traumatic plastic surgery? ☐ Yes ☐ No Percentage of patients _____ %

40. Do you perform cosmetic plastic surgery? ☐ Yes ☐ No Percentage of patients _____ %

    ***If yes, do you perform?***

    a. Rhinoplasties? ☐ Yes ☐ No Percentage of patients _____ %
    b. Hair transplants or suturing of hairpieces? ☐ Yes ☐ No Percentage of patients _____ %
    c. Hair implants? ☐ Yes ☐ No Percentage of patients _____ %
    d. Silicone injections? ☐ Yes ☐ No Percentage of patients _____ %
    e. Silicone implants? ☐ Yes ☐ No Percentage of patients _____ %
    f. Other cosmetic surgery? ☐ Yes ☐ No Percentage of patients _____ %

41. Do you use X-ray for any purpose? ☐ Yes ☐ No
    a. Diagnostic purpose? ☐ Yes ☐ No
    b. Therapeutic purposes? ☐ Yes ☐ No
    c. Do you possess or use radioactive materials?
       1. for diagnostic purposes? ☐ Yes ☐ No
       2. for therapeutic purposes? ☐ Yes ☐ No

       Describe materials used _____

42. Do you engage in the practice of acupuncture? ☐ Yes ☐ No
    a. For anesthesia? ☐ Yes ☐ No
    b. For therapy? ☐ Yes ☐ No
    c. What percentage of your patients are involved with acupuncture? _____ %
    d. If acupuncture is used, please submit certificates of completion from any course taken, and indicate the instructor's name and the number of hours of instruction. ***(Please provide name and number of hours on the Comments page)***

43. a. Do you perform any surgery in your office? ☐ Yes ☐ No
    Do you perform any surgery in any other non-hospital facility? ☐ Yes ☐ No

    ***If yes, please list facilities where such surgery is performed:***

    _____

    b. In the course of surgery described above, is general anesthesia administered? ☐ Yes ☐ No
       1. By you in your office or any other non-hospital facility? ☐ Yes ☐ No
       2. By others in your office or any other non-hospital facility? ☐ Yes ☐ No
    c. List the surgical procedures you perform in your office or other non-hospital facility.

    _____

44. Do you perform the following procedures? Check Yes or No.

| | | | | | |
|---|---|---|---|---|---|
| a. Coronary angiography? | ☐ Yes | ☐ No | r. Paracentesis? | ☐ Yes | ☐ No |
| b. Non-coronary angiography? | ☐ Yes | ☐ No | s. Phlebography? | ☐ Yes | ☐ No |
| c. Amniocentesis? | ☐ Yes | ☐ No | t. Polypectomy by endoscopy? | ☐ Yes | ☐ No |
| d. Bronchoscopy? | ☐ Yes | ☐ No | u. Renal dialysis? | ☐ Yes | ☐ No |
| e. Arteriography? | ☐ Yes | ☐ No | v. Thoracentesis? | ☐ Yes | ☐ No |
| f. Colonoscopy? | ☐ Yes | ☐ No | w. Cardiac catheterization? | ☐ Yes | ☐ No |
| g. Cyrosurgery? | ☐ Yes | ☐ No | x. Convulsive shock therapy? | ☐ Yes | ☐ No |
| h. Dermabrasion? | ☐ Yes | ☐ No | y. Lymphangiography? | ☐ Yes | ☐ No |
| i. Discography? | ☐ Yes | ☐ No | z. Pneumoencephalography? | ☐ Yes | ☐ No |
| j. Endoscopy? | ☐ Yes | ☐ No | A. Radiopaque dye injection? | ☐ Yes | ☐ No |
| k. Esophagoscopy? | ☐ Yes | ☐ No | B. Chelation therapy? | ☐ Yes | ☐ No |
| l. Hypnosis? | ☐ Yes | ☐ No | C. Arthroscopy or arthrography? | ☐ Yes | ☐ No |
| m. Insertion of IUD? | ☐ Yes | ☐ No | D. Peripheral nerve surgery? | ☐ Yes | ☐ No |
| n. Laser therapy? | ☐ Yes | ☐ No | E. FDA approved experiments? | ☐ Yes | ☐ No |
| o. Myelography? | ☐ Yes | ☐ No | F. Sex change? | ☐ Yes | ☐ No |
| p. Phalloplasty? | ☐ Yes | ☐ No | G. Refractive surgery? | ☐ Yes | ☐ No |
| q. Organ transplants? | ☐ Yes | ☐ No | H. Liposuction? | ☐ Yes | ☐ No |

45. Do you perform any of the following procedures which may be defined as ***Major Surgery***? ☐ Yes ☐ No

***If yes, please underscore procedure(s) performed and give percentage of total practice.***

| | **If yes, what percentage *of total practice*** | |
|---|---|---|
| | **As Surgeon** | **As Assistant** |
| a. **Major Surgery** – which shall be defined as (1) any surgical procedure involving cutting into or within the abdominal cavity, cranial cavity, chest cavity, orbital cavity, spine or facial sinuses; (2) orthopedic surgery (other than orthopedic operations on the interphalangeal joints); (3) any amputations; (4) plating, pinning or open reduction of fractures; (5) mastectomy; (6) plastic or cosmetic surgery; (7) reconstructive vascular surgery, thromboembolectomy and thrombectomy of the arteries and veins; (8) ophthalmic surgery; (9) mastoidectomy; (10) operations within the middle or inner ear; (11) prostatectomy; (12) submucous nasal resections; (13) thyroidectomy; (14) neurological surgery; (15) any surgical procedure on malignant lesions except for diagnostic purposes; (16) any cutting into or on the kidney, ureter or bladder; (17) obstetrics. | _____ % | _____ % |
| b. Indicate below any other procedure that you perform which may be defined as **Major Surgery**. | | |
| _____ | _____ *%* | _____ *%* |
| _____ | _____ *%* | _____ *%* |

c. Do you **assist** at major surgery **on other than your own patients**? ☐ Yes ☐ No

46. Do you perform any of the following procedures which may be defined as **Advanced Intermediate Surgery**?.... ☐ Yes ☐ No

***If yes, please underscore procedure(s) performed and give percentage of total practice.***

| | **If yes, what percentage *of total practice*** | |
|---|---|---|
| | **As Surgeon** | **As Assistant** |
| a. **Advanced Intermediate Surgery** – which shall be defined as (1) myringotomy; (2) tonsillectomy & adenoidectomy; (3) herniorrhaphy (inguinal or femoral only); (4) hemorrhoidectomies & other procedures limited to the anal ring. | _____ *%* | _____ *%* |

47. Do you perform any of the following procedures which may be defined as ***Intermediate Surgery***?..... ☐ Yes ☐ No

***If yes, please underscore procedure(s) performed and give percentage of total practice.***

| | **If yes, what percentage *of total practice*** | |
|---|---|---|
| | **As Surgeon** | **As Assistant** |
| a. **Intermediate Surgery** – which shall be defined as (1) vasectomies & other procedures involving the cutting of the scrotal sac; (2) dilation & currettage of the uterus (excluding abortions); (3) injection treatment of varicose veins; (4) orthopedic operations on the interphalangeal joints; (5) circumcision. | _____ *%* | _____ *%* |

48. Indicate below any other procedures that you perform which may be defined as Advanced Intermediate Surgery or Intermediate Surgery.

| | **As Surgeon** | **As Assistant** |
|---|---|---|
| _____ | _____ *%* | _____ *%* |
| _____ | _____ *%* | _____ *%* |

49. Do you perform any of the following?
   a. Surgical treatment of cysts, abscesses and traumatic wounds? ..... ☐ Yes ☐ No
   b. Biopsy procedures of lesions on the skin, and of the mucous membranes on the mouth, nose, throat, vagina, uterine cervix and rectum? ..... ☐ Yes ☐ No
   c. Biopsy excision of lymph nodes within the subcutaneous tissue? ..... ☐ Yes ☐ No

## VII. Specialists

50. **ANESTHESIOLOGISTS**
   a. Do you practice medicine or surgery other than anesthesia?..... ☐ Yes ☐ No Percent of patients _____ *%*
   b. Describe other medicine or surgery performed. ***Please provide details on Comments Page.***
   c. Do you employ _____ or have you assumed supervisory duties _____ over (check one):
      1. Any nurse anesthetists? ..... ☐ Yes ☐ No
      2. Any inhalation therapists? ..... ☐ Yes ☐ No

51. **DERMATOLOGISTS**
   a. Do you perform superficial X-ray therapy? ..... ☐ Yes ☐ No
   b. Do you perform deep X-ray therapy? ..... ☐ Yes ☐ No

52. **GENERAL AND THORACIC SURGEONS**
   a. Do you perform organ transplants? ***If yes, please provide details on Comments Page***..... ☐ Yes ☐ No
   c. Do you perform any surgery that is categorized as:
      1. Orthopedic surgery?..... ☐ Yes ☐ No
      2. Neurosurgery?..... ☐ Yes ☐ No
      3. Obstetrics? ***If yes, please provide on Comments Page***..... ☐ Yes ☐ No
      4. Cardiovascular surgery?..... ☐ Yes ☐ No

53. **OBSTETRICIANS AND GYNECOLOGISTS**

a. Do you limit your practice to gynecology only? ☐ Yes ☐ No

54. **OPHTHALMOLOGISTS**

a. Do you perform transplants? ***If yes, please provide details on Comments Page.*** ☐ Yes ☐ No

b. Do you practice Otolaryngology? ☐ Yes ☐ No

55. **ORTHOPEDIC SURGEONS**

a. Do you perform neurological surgery? ☐ Yes ☐ No

1. On spinal nerves? ☐ Yes ☐ No
2. On peripheral nerves? ☐ Yes ☐ No

***If yes, please explain on the Comments Page dates and location of training in NEUROSURGERY, not Orthopedics***

b. Do you perform lumbar laminectomies? Indicate the number performed annually ☐ Yes ☐ No

***If yes, are lumbar laminectomies performed in conjunction with a neurosurgeon?*** ☐ Yes ☐ No

c. Do you perform cervical laminectomies? Indicate the number performed annually. ☐ Yes ☐ No

***If yes, are cervical laminectomies performed in conjunction with a neurosurgeon?*** ☐ Yes ☐ No

d. Do you perform bone fusion only? ☐ Yes ☐ No

56. **OTOLARYNGOLOGISTS**

a. Do you perform ophthalmic surgery? ☐ Yes ☐ No

57. **PEDIATRICIANS**

a. What percentage of your practice is neonatology? _____ %

b. Do you practice any pediatric oncology? ☐ Yes ☐ No

c. Do you cover any pediatric ICU? ☐ Yes ☐ No

d. Is your practice hospital-based? ☐ Yes ☐ No

## VIII. Other Professional Duties

58. Do you provide professional services as an employee of, contractor for, or staff member of any facility designated for or providing any emergency care? ☐ Yes ☐ No

a. Give full legal name and location of facility(ies), as well as any department in which you serve.

_____

_____

_____

b. Is insurance coverage provided for your work by the facility? ☐ Yes ☐ No

c. Is your work at this facility:

1. On your own patients only? ☐ Yes ☐ No
2. Required for staff privileges? ☐ Yes ☐ No
3. Any of above on a fee basis? ☐ Yes ☐ No
4. Other? Please describe.

_____

_____

d. Is there a written contract or agreement to provide emergency service? ☐ Yes ☐ No

***Please submit copy of written contract.***

59. Do you provide professional services as an employee of, contractor for or staff member of any of the following:

a. Any health care facility having bed and board accommodations?..... ☐ Yes ☐ No

b. Any clinic, foundation, blood bank, laboratory or surgi-center? ..... ☐ Yes ☐ No

c. Any medical service facility maintained by an industrial firm? ..... ☐ Yes ☐ No

d. Any health maintenance organization, pre-paid health plan?..... ☐ Yes ☐ No

***If yes, give full legal name and location of facility as well as any department in which you serve.***

_____

_____

1. Is insurance coverage provided for your work by the facility?..... ☐ Yes ☐ No
   (Other than the coverage being applied for)
2. Are you?
   - ☐ Owner (whole or part)
   - ☐ Executive Officer
   - ☐ Administrator
   - ☐ Department or Ancillary Service Director
   - ☐ Physician with teaching responsibilities
   - ☐ Other (Describe)

   _____
3. How many days per week do you work at the facility? _____
4. How many hours per day do you work at the facility?_____
5. Indicate number and specific professional classification of any assistant working under your supervision or for whom you have assumed legal responsibility:

   No._____ Class _____

   No._____ Class _____

   No._____ Class _____

   No._____ Class _____

## IX. Comments

***Please use this space for additional comments as requested on previous pages. Include question number at beginning of response.***

***Attach additional sheets, if necessary.***

## X. Agreement

I do hereby certify the truth of my statements and answers mentioned herein, and that I have not withheld any material information.

I understand that the withholding of any information which is calculated to influence the judgment of the company in considering this request for a premium indication will release the Company from any obligation incurred hereunder.

The application form duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature of the form does not bind the applicant or the Company to complete the insurance.

**X**_____ (_____) _____ _____/_____/_____

***(SIGNATURE OF APPLICANT)*** ***(APPLICANT'S OFFICE PHONE NUMBER)*** ***(DATE SIGNED)***

I hereby authorize release and exchange of information between my medical association or society and their insurance consultants, any hospital I presently or previously held staff privileges with, and prior insurance carriers involving past and future underwriting and claims matters.

I further agree that the organization releasing the information, its agents, servants and employees, shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information.

**X**_____ (_____) _____ _____/_____/_____

***(SIGNATURE OF APPLICANT)*** ***(APPLICANT'S OFFICE PHONE NUMBER)*** ***(DATE SIGNED)***

**Note: Signatures are required in two places above. Missing signatures will delay the processing of your application.**

## X. SUPPLEMENTAL CLAIMS INFORMATION

***(Please use photocopies of this form for each additional claim.)***

1. Name, age, and sex of patient _____

   _____

2. Date of first consultation_____

3. Physical condition and diagnosis at above date _____

   _____

   _____

   _____

   _____

4. Date of treatment given and nature of same _____

   _____

   _____

   _____

   _____

5. Date of claim, and allegations made against you _____

   _____

   _____

   _____

   _____

   _____

6. Disposition of claim, amount of judgment or settlement _____

   ☐ Open Claim – Reserve $ _____ ☐ Settlement, or

   ☐ Closed Claim – Loss $ _____ Date Closed: _____ ☐ Judgment

7. What insurance company, if any, was involved? _____ Policy No. _____

8. Subsequent condition of health of patient _____

   _____

   _____

9. Names of other doctors, if any, involved in the claim or suit _____

10. To whom may we refer for further information about the suit? _____

Please type or print name: _____

**X**_____ **X** _____

***(DATE COMPLETED)*** ***(SIGNATURE OF APPLICANT)***