LOSS INFORMATION SUPPLEMENTAL

Return Applications to: **Rockwood Programs, Inc.**
3001 Philadelphia Pike, Claymont, DE 19703
Tel: 800-365-0816 • Fax: 302-764-9125 • www.rockwoodinsurance.com

Applicant Name _____

Please complete the following information for each applicant involved in each claim. Please make copies if additional forms are needed for multiple claims 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. □ 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), surgery center(s) or healthcare provider(s), if any, involved: _____

_____

G. 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: $ _____

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:

_____

_____

_____

_____