Red Mountain®
CASUALTY
A ProAssurance Company

AltaCover℠
HEALTH CARE PROFESSIONAL LIABILITY INSURANCE APPLICATION
DENTISTS AND ORAL SURGEONS

With your fully completed, signed and dated application, you ***must*** submit the following information:

1. Current insurance policy declarations page.
2. Written verification of the purchase of a reporting endorsement from your present carrier if your current coverage is claims-made.
3. Current business letterhead.
4. Copy of all licenses and board certifications.
5. Currently valued loss runs from all prior insurance companies.
6. Copy of curriculum vitae.
7. Articles of Incorporation, if applicable.

NOTE: ***SUBMISSION OF A COMPLETED APPLICATION CONFERS NO OBLIGATION UPON THE COMPANY TO BIND COVERAGE.***

Healthcare Professional Services, Inc
313 Swanson Drive*Lawrenceville, GA 30043
(800) 423-1520 / (888) 206-2024 fax

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NOTE: If any space provided herein is insufficient for complete reply, please use Page 13, and/or a separate sheet, identifying by number the questions you answer.

1. PERSONAL INFORMATION

A. Full Name of Applicant: ______________________________
FIRST MIDDLE LAST

B. Date of Birth: ______________ C. Place of Birth: ______________________
MONTH DAY YEAR

D. Social Security Number: ______________________________

E. Home Address: ______________________________

____
CITY STATE ZIP

F. Home Telephone:( )______________ G. E-mail Address (if applicable): ______________

2. OFFICE INFORMATION

A. Principal Office Address: ______________________________

____

____
CITY STATE ZIP

Indicate the county in which your office is located: ______________________

B. Office Phone Number: ( )______________ C. Office Fax Number: ( ) ______________

Please check this box if your Principal Office Address is not actually located within the city limits of the city to which your mail is addressed. .... ☐

D. Secondary Office Locations (if any): ______________________________

____

____
CITY STATE ZIP

E. Secondary Office Phone No.: ( ) __________ F. Secondary Office Fax No.: ( )__________

G. Preferred billing address: ☐ Principal Office ☐ Secondary Office ☐ Home

H. Percentage of practice at each of the above locations: ____ Principal Office ____ Secondary Office

3. COVERAGE SELECTION

Requested Effective Date:______________________
MONTH DAY YEAR

A. Please indicate your desired level of coverage by placing an “X” in the appropriate box.

- ☐ $100,000 / $300,000
- ☐ $200,000 / $600,000
- ☐ $250,000 / $750,000
- ☐ $500,000 / $1,500,000
- ☐ $1,000,000 / $3,000,000
- ☐ $2,000,000 / $6,000,000 (Available only in the state of Virginia)

B. A deductible of at least $5,000 is required. Please select any optional deductible that you desire. No aggregate will apply to the deductible.

☐ $10,000 ☐ $25,000 ☐ $50,000

Coverage will become effective only after the completion of all underwriting functions and acceptance by the Company.

4. RATING INFORMATION

A. What is your present specialty? ______________________

B. What is your present sub-specialty? ______________________

C. What percentage of your practice is devoted to your specialty? ______________ %

D. What percentage is devoted to your sub-specialty? ______________ %

E. Procedures you perform:

- ☐ Extractions
- ☐ Implants (Surgical Placement)
- ☐ Root canals
- ☐ Minor (Alveolar) Oral Surgery
- ☐ Major Oral Surgery
- ☐ Facial cosmetic (please describe): ______________________
- ☐ Other: ______________________

F. Have there been any changes in your specialty or practice activities (including the addition of new procedures) within the past ten years? .... YES ☐ NO ☐

Important: If "yes", describe the nature of changes in specialty or practice activities on Page 13 and/or a separate sheet.

G. Are you Board Certified? .... YES ☐ NO ☐

i. Specialty Board: ______________________

ii. Date of Board Certification: ______________________

H. Indicate the average number of: Patients seen per week: ________ Hours practiced per week: ________

I. Do you now or have you ever provided services to any state, local or federal correctional facility, jail or prison? .... YES ☐ NO ☐

If "yes", please explain: ______________________

J. Do you treat patients in a nursing home or similar facility? .... YES ☐ NO ☐

If "yes", how many patients do you treat there per month, on average? ______________

5. LICENSING INFORMATION – LIST ALL STATES IN WHICH YOU ARE LICENSED TO PRACTICE

State	License Number	% of Practice	Which County?	Member of State Dental Association?
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐

6. MANAGED CARE CONTRACT INFORMATION

NAME AND MAILING ADDRESS OF MANAGED CARE ORGANIZATION	APPROXIMATE % OF TOTAL PATIENTS	CAPITATED? (CIRCLE ONE)	ISSUE CERTIFICATE OF INSURANCE? (CIRCLE ONE)
		YES NO	YES NO
		YES NO	YES NO
		YES NO	YES NO

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7. ANESTHESIA QUESTIONNAIRE

If you administer only local anesthesia you may skip this section and go to Section 8. If you administer any anesthesia other than local, you must complete this section.

A. Anesthesia Training/Education

i. Describe your anesthesia training. ____

____

ii. Are you ☐ BCLS, ☐ ACLS or ☐ ATLS certified? (Check all that apply.)

iii. List Continuing Education courses you have taken in the last 5 years that are related to the use of anesthesia in an office setting.

____

____

____

iv. During the last 5 years, have you participated in an office Self-Evaluation Program performed by your peers? .... YES ☐ NO ☐

B. Methods Utilized

Indicate if and where you use/perform any of the following as defined below the table.

TYPE OF ANESTHESIA		LOCATION (CHECK ALL THAT APPLY)		
Local anesthesia	☐Y ☐N	☐Office	☐Surgery Center	☐Hospital
Minimal sedation (Anxiolysis), including administration of nitrous oxide	☐Y ☐N	☐Office	☐Surgery Center	☐Hospital
Moderate sedation/Analgesia (Conscious sedation)	☐Y ☐N	☐Office	☐Surgery Center	☐Hospital
Deep sedation/Analgesia	☐Y ☐N	☐Office	☐Surgery Center	☐Hospital
General anesthesia	☐Y ☐N	☐Office	☐Surgery Center	☐Hospital

Minimal Sedation (Anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

C. Personnel

i. List the names of others in your office that are certified.

FULL NAME OF EMPLOYEE / CONTRACTOR	TITLE / TYPE OF EMPLOYEE	TYPE OF CERTIFICATION
		☐ACLS ☐BCLS
		☐ACLS ☐BCLS
		☐ACLS ☐BCLS
		☐ACLS ☐BCLS

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ii. If you use contractors, how do you verify insurance, credentials and competency of contracted staff?

____

____

____

D. Equipment

i. Indicate which types of equipment are available and properly maintained in your office.

Equipment	Available	Equipment	Available
ECG	☐Y ☐N	Temperature monitor	☐Y ☐N
Oxygen source	☐Y ☐N	IV set-up	☐Y ☐N
Defibrillator	☐Y ☐N	Blood pressure monitor	☐Y ☐N
AMBU bag	☐Y ☐N	Resuscitative & emergency drugs (crash cart)	☐Y ☐N
Suction apparatus	☐Y ☐N	Pulse oximeter	☐Y ☐N
Intubation equipment	☐Y ☐N		

ii. Who is responsible for maintaining the equipment and drugs? ______________________________

____

iii. Do you have an emergency power supply? .... YES ☐ NO ☐

iv. How many bottles of oxygen do you keep on the premises? ______________________________

v. Do you have a scavenging system for anesthetic gases? .... YES ☐ NO ☐

E. Pre-anesthesia Procedures

i. Who performs a history and physical examination on the patient prior to administration of anesthesia? ______________________________

ii. Who documents this history and physical? ______________________________

iii. Does the history and physical include information concerning previous experiences with anesthesia? .... YES ☐ NO ☐

iv. Are written discharge instructions provided to the patient or a responsible adult prior to the procedure? .... YES ☐ NO ☐

F. Intra-anesthesia Procedures

i. Who performs the administration of anesthesia in your office? ______________________________

ii. Is there a second individual monitoring the patient during the administration of anesthesia? .... YES ☐ NO ☐

If "yes", what are this individual's qualifications? ______________________________

iii. How frequently do you monitor heart rate, blood pressure and temperature during anesthesia administration? ______________________________

iv. Who documents intra-anesthesia monitoring? ______________________________

v. Do you use pulse oximetry for patients under any level of anesthesia? .... YES ☐ NO ☐

If "no", please explain. ______________________________

____

vi. Are you equipped and trained to use positive pressure endotracheal respiratory assistance? .... YES ☐ NO ☐

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vii. Do you intubate patients for airway maintenance under: Deep sedation? .... YES ☐ NO ☐

General anesthesia? .... YES ☐ NO ☐

viii. How far is it from your office to the nearest hospital? ____________________

ix. Do you have protocols and transfer agreements in place for patients who suffer adverse outcomes or who cannot be discharged home from the office? .... YES ☐ NO ☐

x. How does your practice respond to emergencies?

☐ begin CPR ☐ call 911 ☐ have a code team

☐ all of the above ☐ none of the above

xi. Does your staff conduct practice drills for medical emergencies? .... YES ☐ NO ☐

If "yes", how many times per year are these drills conducted? ____________________

G. Post-anesthesia Procedures

i. What is the **minimum** time a patient is monitored following anesthesia? Indicate in minutes and/or hours. ____________________

ii. Who performs the post-anesthesia monitoring? ____________________

iii. Does a practitioner qualified in post-anesthesia care remain in the office until the patient is discharged? .... YES ☐ NO ☐

What are the qualifications of this individual? ____________________

____

iv. Do you have established and written discharge criteria for patients receiving anesthesia? .... YES ☐ NO ☐

If "yes", do all patients meet these criteria prior to discharge? .... YES ☐ NO ☐

Is this fact documented in the patient's record? .... YES ☐ NO ☐

v. Are written discharge instructions provided to the patient or a responsible adult prior to discharge? .... YES ☐ NO ☐

H. Pediatric Anesthesia

i. Does your practice include pediatric patients? .... YES ☐ NO ☐

If "yes", what is the youngest patient the practice will treat using anesthesia? ____________________

ii. At what age is a patient no longer considered to be pediatric? ____________________

iii. What types of anesthesia (as described in section B above) do you use on pediatric patients? ______

____

iv. What anesthetic drugs are used on pediatric patients? ____________________

____

v. Is your staff trained in pediatric drug conversions? .... YES ☐ NO ☐

vi. Is your staff trained to respond to a pediatric emergency? .... YES ☐ NO ☐

vii. Do transfer agreements include transfer of pediatric patients to appropriate facilities? .... YES ☐ NO ☐

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8. EDUCATIONAL INFORMATION

DENTAL AND MEDICAL SCHOOL DATA			
NAME OF DENTAL/MEDICAL SCHOOL(S) ATTENDED	LOCATION OF SCHOOL(S) ATTENDED	DEGREE	DATE GRADUATED

If you are a foreign graduate, are you certified by the Education Council for Foreign Medical School Graduates?... YES ☐ NO ☐

POST-GRADUATE TRAINING					
INSTITUTION AND LOCATION			DATES (MONTH/YEAR)		COMPLETED?
NAME	LOCATION	DEGREE OBTAINED	START	END	CIRCLE ONE
					YES NO*
					YES NO*
					YES NO*

* IF "NO" CIRCLED, EXPLAIN FULLY ON PAGE 13 AND/OR A SEPARATE SHEET

OTHER RELATED EDUCATION COMPLETED IN THE PAST THREE YEARS		
COURSES COMPLETED	CREDITS RECEIVED	DATE(S) ATTENDED MONTH/YEAR

9. HOSPITAL AFFILIATIONS AND PRIVILEGES

HOSPITALS WHERE YOU HAVE, OR HAVE HAD, ACTIVE PRIVILEGES					
HOSPITAL DATA		DATES (MONTH/YEAR)		% OF YOUR PATIENTS ADMITTED TO THIS FACILITY	ISSUE CERTIFICATE OF INSURANCE? (CIRCLE ONE)
NAME	MAILING ADDRESS	START	END		
					YES NO
					YES NO
					YES NO

10. PRACTICE HISTORY

PLEASE LIST LOCATIONS WHERE YOU HAVE PRACTICED SINCE RESIDENCY		
LOCATIONS	DATES (MONTH/YEAR)* START	END

*PROVIDE BRIEF DESCRIPTION OF EACH PRACTICE SITUATION, INCLUDING CLINICAL RESPONSIBILITIES, AND EXPLAIN ANY GAPS IN PRACTICE ON PAGE 13 AND/OR A SEPARATE SHEET

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11. PRACTICE ORGANIZATION

A. Please check all that apply and provide details. If vicarious liability coverage is desired, so indicate.

☐ Solo Entity: Name ________________________________

Corp. Tax ID # ________________ Date of Incorporation ________________ ☐ Coverage Requested

☐ Member of a partnership or multi-shareholder corporation: ________________________________

Partnership/Group Name ________________________________

Corp. Tax ID # ________________ Date of Incorporation ________________ ☐ Coverage Requested

☐ Other (i.e., implied partnership, corporation, etc.):

Entity Name ________________________________

Corp. Tax ID # ________________ Date of Incorporation ________________ ☐ Coverage Requested

Please include Articles of Incorporation, accompanied by a list of principals, and a copy of your business letterhead.

B. Give the full names of all other dentists affiliated with any organization(s) named in Question 11A. Use Page 13, if necessary.

NAME	CURRENT PROFESSIONAL LIABILITY INSURANCE CO.

12. INFORMATION ON ALLIED HEALTH CARE PROFESSIONALS

A. List below any of the following professionals associated with your practice:

Certified Registered Nurse Anesthetists, Surgical Assistants, Registered Nurses or Licensed Practical Nurses

Please indicate if coverage is desired for these individuals. A separate application will be required for each individual for whom coverage is requested.

NAME	SPECIALTY	EMPLOYMENT STATUS	TO BE CONSIDERED FOR SHARED LIMITS COVERAGE?
		☐ Employee ☐ Contractor	☐ Yes ☐ No
		☐ Employee ☐ Contractor	☐ Yes ☐ No
		☐ Employee ☐ Contractor	☐ Yes ☐ No

B. Indicate the number of the following types of employees who provide services in your office:

NUMBER	POSITION	NUMBER	POSITION
	Dental Assistant		Laboratory Technician
	Dental Hygienists		Other:
	X-Ray Technician		

C. Please indicate the number of miscellaneous dental professionals in your employ: ________________

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13. PROFESSIONAL LIABILITY INSURANCE HISTORY

NAME OF COMPANY (CURRENT)	POLICY LIMITS	PERIOD OF COVERAGE: RETROACTIVE DATE:	☐ CLAIMS-MADE ☐ OCCURRENCE
NAME OF COMPANY	POLICY LIMITS	PERIOD OF COVERAGE: RETROACTIVE DATE:	☐ CLAIMS-MADE ☐ OCCURRENCE
NAME OF COMPANY	POLICY LIMITS	PERIOD OF COVERAGE: RETROACTIVE DATE:	☐ CLAIMS-MADE ☐ OCCURRENCE

A. Have you ever applied to Mutual Assurance, Medical Assurance, ProNational Insurance Company, Red Mountain Casualty or ProAssurance for insurance before?...................... YES ☐ NO ☐

B. If you have been insured under a Claims-Made policy, are you requesting that the Company provide prior acts coverage?.. YES ☐ NO ☐

C. If the Company does not offer you prior acts coverage, will you purchase “tail” coverage from your current carrier? If not, please explain on Page 13. .... YES ☐ NO ☐

D. Has any insurance company (including Lloyds of London) ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? Important: If yes, please provide complete explanation on Page 13. .... YES ☐ NO ☐

Important information regarding questions 13E and 13F (including sub-questions):

1. The word "claim" as used in Questions 13E and 13F following refers to:
   a. 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; or
   b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer “yes” to any parts of questions 13E or 13F, please complete the attached Supplementary Claims Information Form on page 14 for all such claims.

E. Have you ever been involved in a malpractice claim or suit, either directly or indirectly?.. YES ☐ NO ☐

If yes, how many?_________________________

F. Other than the claims/suits indicated in 13E, are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit?

i. A request for records from a patient and/or attorney related to an adverse outcome? .... YES ☐ NO ☐

ii. A letter from an attorney regarding your medical treatment of a patient?.................. YES ☐ NO ☐

iii. Intra-operative or post-operative complications or other complications resulting in death, paralysis, other significant disability or the need for follow-up surgery? .... YES ☐ NO ☐

iv. Patient or family member dissatisfaction with the outcome of a procedure, treatment or diagnosis? .... YES ☐ NO ☐

v. Any other circumstances that might reasonably lead to a claim or suit? .... YES ☐ NO ☐

vi. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? .... YES ☐ NO ☐

a. If "Yes", how many?_______________
   Please attach documentation of all such reports.

b. If "No", please explain on Page 13.

For purposes of this question, check the following box if you are aware of no circumstances that might reasonably lead to a claim or suit. .... Not Applicable ☐

Important: **If you answer "yes" to questions 13G through 13P, please provide details on Page 13, and/or a separate sheet.**

G. Has your license to practice or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? .... YES ☐ NO ☐

H. Have your hospital staff privileges ever been suspended, revoked, voluntarily surrendered, or in any way restricted? .... YES ☐ NO ☐

I. Have you ever failed any licensing or Board Certification examinations? .... YES ☐ NO ☐

   If yes, how many times?______

J. Have you ever been refused hospital privileges? .... YES ☐ NO ☐

K. 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 or Dental Examiners, or other medical or dental review committee? .... YES ☐ NO ☐

L. Have you ever had a patient or a patient representative complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical of Dental Examiners, or other medical or dental review committee?.................... YES ☐ NO ☐

M. Have you ever been convicted of or pled guilty 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 ☐

N. 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 other mental illness, including but not limited to depression and/or chronic fatigue? .... YES ☐ NO ☐

O. Have you ever been accused of sexual misconduct of any kind?.................................... YES ☐ NO ☐

P. Do you have any physical handicap or any chronic illness? .... YES ☐ NO ☐

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IMPORTANT! YOU MUST READ CAREFULLY.

GENERAL FRAUD WARNING

Any person who knowingly includes any false or misleading information on an application for an insurance policy or files a claim containing a false or deceptive statement is guilty of insurance fraud and is subject to criminal and civil penalties.

SPECIFIC CONSENT TO CONDITIONS OF CONSIDERATION OF THE APPLICATION FOR INSURANCE

With the submission of this application for insurance, 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 that may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, its directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection, or approval for insurance, and any communications, reports, records, statements, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I hereby declare and warrant that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete and correct and that I have not deliberately suppressed or misstated any material facts. I understand that this is an application for insurance and not an insurance binder.

I acknowledge that acceptance into the Company's insurance program is not a right of every licensed applicant who makes application for insurance, and that my application will be evaluated by authorized personnel. Submission of a payment or deposit with this application and provisional receipt of such payment by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment shall be returned to the applicant.

_______________________________ **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 liability. The following page of this Application is an ***Authorization To Release Information*** form which requires your signature. Please read carefully.

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AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by RED MOUNTAIN CASUALTY INSURANCE COMPANY OR PRONATIONAL INSURANCE COMPANY (the "Company") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all professional associations and societies in which he is or has been a member, all hospitals in which he now holds or has held staff privileges, any Board of Professional Examiners or Licensure Commission for any state in which he has practiced or resided, and any and all physicians, dentist or any other third party having information regarding the undersigned, to release to the Company upon its request any information that any such person or entity may have which in the judgment of such person or entity or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a copy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): ______________________________

Signature: ______________________________

Address: ______________________________

____

Date: ______________________________

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ADDITIONAL COMMENTS

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Supplementary Claims Information Form

If reporting more than one claim, please photocopy this form. Attach additional sheets if needed for adequate explanation. 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. Date of incident and your treatment: ____________________
5. Allegations: ____________________

____

____

6. What is the present condition of the patient? ____________________

____

7. 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 ☐

8. Status of claim (check applicable answer):

☐ Suit threatened, no action taken
☐ Suit filed but dropped by claimant
☐ Summary judgment in your favor

☐ Suit settled out of court
a. Date claim paid: ____________
b. Amount paid: $ ____________
c. Did you want to settle this claim? ☐YES ☐NO

Court outcome in your favor:
☐Jury verdict
☐Directed verdict

Court outcome in favor of plaintiff:
☐Jury verdict
☐Directed verdict
Amt. of Loss Payment:
$ ____________

☐ Awaiting mediation

☐ Awaiting court action

Reserve Amount:
$ ____________

9. Name and address of the attorney assigned to your case: ____________________

____

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 $ ____________________

11. Explain, in detail, what action(s) you have taken to prevent recurrence of this type of claim. ____________

____

____

____

Signature: ____________________ Date: ____________________

Name (Printed): ____________________

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