

AMERICAN PHYSICIANS ASSURANCE CORPORATION

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Supplemental Claim Information Form

Please copy this form and provide the information below for each additional claim or suit to report.

Please type or legibly print your responses in full.

- 1. Health Care Provider Name: _____ 2. MD DO Other: _____
- 3. Patient's Name: _____ 4. Age: _____ 5. Male Female
- 6. Date of first consultation: _____
- 7. Physical condition and diagnosis at the above date: _____

- 8. Nature of treatment given and dates of same: _____

- 9. Date of **incident or occurrence** from which the claim resulted: _____
- 10. Date of claim: _____
- 11. Allegations made against you: _____

- 12. Was this claim reported to your insurance carrier? Yes No
If yes, list name of carrier and policy number: _____

- 13. Present status or disposition of claim including **amount of settlement or judgment**: _____

- 14. Subsequent condition or health of patient: _____

- 15. Names of other doctors and hospitals, if any, involved in the claim or suit: _____

- 16. To whom may we refer for further information about the claim? _____

Date Completed
Clms Supp Form (03/04)

Name (Please Print)

Signature of Applicant