claim

**NOTICE OF LOSS EVENT**

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| **FIRST NAMED INSURED AND POLICY INFORMATION** | Name | | Policy/Certificate No. | | | Professional Liability  General Liability  Other | |
| Address | | Effective Dates | | | | |
| Contact Person and Phone Number | | Limits | | | | |
| If reporting under an excess policy provide the following: | | | | | | |
| Underlying Carrier(s) Name(s)    Contact Person(s) and Phone Number(s) | | Underlying Limit(s)    Current Loss Reserve(s) | | | | |
| **LOCATION AND DATE OF INCIDENT** | Location (Including City and State) | | Time | Date | | | |
| **CLAIMANT AND INJURY DETAILS** | Name and Address | | Social Security No. | Sex | | | DOB |
| Describe Injuries | | Occupation | | | | |
| **GENERAL INFORMATION** | Patient Admitted Date | Patient Discharged Date | | | Treating Physician(s) | | |
| Admitting Diagnosis | | | | | | |
| **DESCRIPTION OF LOSS** | Summary | | | | | | |
| **LITIGATION INFORMATION** | Venue | | Plaintiff Attorney and Firm | | | | |
| Defense Attorney and Firm | | Date of Service on Insured | | | | |
| **REPORTED BY** | Signature or Name of Person Completing Report | | Date | | | | |