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      |