

# Princeton Insurance Company

## Loss Information Supplement

Please make copies if additional forms are needed.

**Applicant's Name:** \_\_\_\_\_

Note: Additional documentation may be requested at Princeton Insurance 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), or health care provider(s), if any, involved.** \_\_\_\_\_

**G. Current status:**     Open     Closed

If open, indicate dollar value established by insurer:    \$ \_\_\_\_\_

If closed:

1. Date of closing:

|    |   |      |  |  |  |
|----|---|------|--|--|--|
|    |   |      |  |  |  |
| MM | / | YYYY |  |  |  |

2. Was a payment made?     Yes     No

a. If yes, did you consent to the settlement?     Yes     No

b. Total amount of settlement or award:    \$ \_\_\_\_\_

c. 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:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_