



Excess Professional Liability Insurance Notice of Claim or Occurrence

A COPY OF ANY DEMAND, NOTICE, SUMMONS OR OTHER PROCESS RECEIVED MUST BE FORWARDED, UPON RECEIPT, TO THE ADDRESS SHOWN BELOW. FAILURE TO SEND NOTICE OF LAWSUITS IMMEDIATELY MAY JEOPARDIZE COVERAGE UNDER YOUR EXCESS INSURANCE POLICY.

Physician name, Mailing address, Phone number, Contact person, Primary hospital affiliation, License number, Specialty, Board certified, Date of birth, DEA number, Medical school attended, Year graduated.

INTERNAL USE ONLY



Other applicable insurance at time of treatment (indicate primary or excess)

Table with columns: CARRIER NAME, POLICY NUMBER, POLICY PERIOD, LIMITS OF LIABILITY (Check One)*

*NOTE: For incidents dated after April 1, 2002, primary limits of \$1.3 million/\$3.9 million required

DO NOT WRITE IN THIS BOX—FOR OFFICE USE ONLY

Large empty box for office use only

Dates of occurrence/treatment, Dates of treatment alleged in Summons & Complaint, Patient's name, Date of birth

Briefly describe the nature of alleged injury

Indicate location where patient was treated

If hospital, your relationship to hospital (i.e. house staff, salaried, private attending)

What are you reporting? (check one):

- Summons & Verified Complaint (include copy)
Attorney's Request Letter
Occurrence (Any unusual event that may give rise to a future claim or a lawsuit such as death, paralysis, paraplegia, spinal cord injury, nerve damage, neurological deficit, brain damage, loss of limb [in whole or in part], sensory or reproductive organ injury, substantial disability or disfigurement.)
Other (please specify)

Send completed form to: Hospitals Insurance Company, Inc. Attn: Claim Department 50 Main Street, Suite 1220 White Plains, NY 10606 PLEASE MAIL CERTIFIED RETURN RECEIPT REQUESTED AND SEND COPIES OF ALL RELATED DOCUMENTS