



SHAND MORAHAN & COMPANY, INC.

Ten Parkway North, Suite 100, Deerfield, Illinois 60015
(847) 572-6000 Fax (847) 572-6137

MEDICAL INCIDENT OR THREAT OF CLAIM FORM FOR PHYSICIAN, SURGEON, DENTIST & PODIATRIST APPLICATIONS

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. This is a mandatory form which must accompany a completed application and supplemental claim information form.
3. PLEASE READ THE STATEMENTS AT THE END OF THIS APPLICATION CAREFULLY.
(PLEASE TYPE OR PRINT IN INK)

1. NAME OF APPLICANT

2. APPLICANT HISTORY

	<u>Yes</u>	<u>No</u>
a. Are you aware of any act, error, omission or circumstance which could result in a malpractice claim or suit being made against you? If Yes, has this been reported to a prior carrier?	[]	[]
SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such medical incident or threat of claim; have you attached the completed form?	[]	[]

	<u>Yes</u>	<u>No</u>
b. To the best of your knowledge, have any of the following adverse results occurred in your practice in the last (5) years:		
(i) Unexpected death (including stillbirths)?	[]	[]
(ii) Unexpected organ failure or significant neurological or functional deficit?	[]	[]
(iii) Failure to diagnose cancer or infection resulting in death or disability of patient?	[]	[]
(iv) Tear or perforation of an organ or body part during an invasive procedure, or unplanned removal of a normal organ or body part during an operative procedure?	[]	[]
(v) Suspicious or positive x-ray, Pap smear or mammogram where patient was not contacted?	[]	[]
(vi) Follow-up/emergency surgery, myocardial infarction or cerebral vascular accident within 48 hours of your previous diagnostic treatment or surgery?	[]	[]
(vii) Complications from improper medication or improper dosage?	[]	[]
(viii) Pathological and/or operative report which do not match?	[]	[]
If yes to any of the above, has it been reported to a prior carrier? If you have NOT reported to a prior carrier, please attach an explanation. SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such adverse result; have you attached the completed form?	[]	[]

c. Has any attorney contacted you (e.g., request for medical records) in connection with any patient that has NOT been disclosed to us? If yes, SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such adverse result; have you attached the completed form?	[]	[]
	[]	[]

d. Does your current professional liability carrier require reporting of an incident or request for records by a patient or attorney?	[]	[]
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	<u>Yes</u>	<u>No</u>
e. Has any prior professional liability carrier refused coverage for, or declined to accept your report of, a medical incident, threat of claim, adverse result or attorney contact? If yes, please attach an explanation.	[]	[]

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same warranty and conditions.

Name of Applicant*

Title

Signature of Applicant

Date

*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete the insurance.

