



Jane M. Benedict, ARM, WCCP **Medical Division Manager**
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ASBP PREFERRED PROVIDER – BARIATRIC PROGRAM - SUPPLEMENTAL CLAIM INFORMATION

1. Applicant Name _____
2. Claimant Name _____
3. Name of Individual(s) at your firm/Company involved in Claim: _____
4. Indicate whether: Claim/Suit, or Incident
5. Date of Alleged Error: _____ Date Claim Made Against Applicant: _____
6. Additional Defendants: _____
7. Current Disposition of Claim:
 - DISMISSED (Action dropped without any payment to claimant or statute of limitations expired)
 - ABANDONED (no activity from claimant for over 3 years)
 - WON BY DEFENSE
 - WON BY CLAIMANT Total Paid \$ _____ Amount Paid on Your Behalf \$ _____
 Court judgment, or Out of court settlement
 - OPEN Claimant's Settlement Demand \$ _____
 OPEN Defendant's Offer for Settlement \$ _____ Insurer's Loss Reserve \$ _____
8. Name of Insurer: _____
9. Description of Claim: (Provide enough information to allow evaluation. Use reverse side if additional space is required.)
 - a. Alleged act, error or omission upon which Claimant bases claim: _____
 - b. Description of cases and events: _____
 - c. Description of the type and extent of injury or damage allegedly sustained: _____
 - d. If a medical claim provide type of injury claimed:
 - Emotional Only Temporary Disability Death
 - Permanent Disability Cosmetic Other _____
10. Explain what action has been taken by you to prevent recurrence of the same type of claim. _____

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 (Officer, partner, etc.)

 Signature of Applicant

 Date