LANCET INDEMNITY
"THE INSURANCE COMPANY PHYSICIANS TRUST"

PROFESSIONAL LIABILITY CLAIMS INFORMATION

(Must Be Printed)

Complete one form for each case **Copies may be made as needed**

Insurance Carrier: _____ Patient Name_____

Date of Occurrence: _____ Date of Suit: _____

Location of Incident: _____

Relationship to Patient (attending physician, surgeon, consultant, etc.)

_____

Primary Defendant: _____ Co-Defendant: _____

Patient Outcome: _____

_____

Allegations made about care rendered: _____

_____

_____

Claim Status (Open, Closed, Pending): _____ Date: _____
If closed, indicate method of closing: (Circle below)

○ DISMISSAL ○ SETTLED ○ JUDGMENT CASE-DROPPED

Amount of settlement/judgment: _____ Date: _____

Physician (print name): _____ Date: _____

I understand that the information submitted here becomes a part of my insurance application and is subject to the same representations and conditions.

Signature of Applicant: _____ Date: _____

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