HPIC
HEALTHCARE
PROFESSIONALS
INSURANCE COMPANY

Hospital Professional/General Liability Notice of Claim or Occurrence

Hospital: _____

Contact Name: _____ Phone: _____

Email Address: _____

What are you reporting? (Check one)

☐ Summons/Complaint ☐ Letter of Claim

Date of Service: ___/___/___ Date Received: ___/___/___

Occurrence Date of Occurrence/Treatment: ___/___/___

Patient's Name: Last: _____ First: _____ DOB: ___/___/___

Marital Status/# Dependants/Occupation (if known):

_____/_____/_____

Briefly describe the nature of the alleged injury: _____
_____
_____
_____

Dates of Occurrence/Treatment Alleged in Summons & Complaint: _____

If Summons/Complaint:

Dates of Occurrence/Treatment alleged in the Summons & Complaint: _____

Please note relationship of all co-defendants to insured:
Eg: employed physician, private attending, employed registered nurse, affiliated entity, non-affiliated entity

Co-Defendant	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Defense Firm/Attorney Assigned: _____

As required by your policy, upon receipt, a copy of any demand, notice, summons or other process received must be forwarded, with this form to:

HPIC 217 Great Oaks Boulevard, Albany, NY 12203 Fax (518) 862-0144