www.HealthcareProfessionalsInsurance.com

EXCESS PROFESSIONAL LIABILITY NOTICE OF CLAIM OR OCCURRENCE

866.374.4742

IT IS A REQUIREMENT OF THIS SECTION OF COVERAGE THAT A COPY OF ANY DEMAND, NOTICE, SUMMONS OR OTHER PROCESS RECEIVED MUST BE FORWARDED, UPON RECEIPT TO THE ADDRESS AT THE BOTTOM OF THIS FORM.

PHYSICIAN'S NAME **LAST** ______________________________ **FIRST** ______________________ **MI** ________

MAILING ADDRESS (❑ *check if change of address*) ____

____

PHONE # ______________________________ **FAX #** ______________________________

CONTACT PERSON & PHONE # *(if different than above)* ______________________________

PRIMARY HOSPITAL AFFILIATION ______________________ **LICENSE #** ______________________

SPECIALTY ______________ **BOARD CERTIFIED Yes** ❑ **No** ❑ **DOB** ______________ **DEA #** ______________

MEDICAL SCHOOL ATTENDED ______________________________ ________**YEAR GRADUATED** ______________

OTHER APPICABLE INSURANCE AT TIME OF TREATMENT *(indicate primary or excess)*

CARRIER NAME	POLICY NUMBER	POLICY PERIOD	CLAIMS EXAMINER	LIMITS OF LIABILITY** *(check one)*
				❑ $1 million/$3 million
				❑ $1.3 million/$3.9 million

DO NOT WRITE IN THIS BOX – FOR OFFICE USE ONLY	DO NOT WRITE IN THIS BOX – FOR OFFICE USE ONLY

DATES OF OCCURRENCE/TREATMENT ____

DATES OF TREATMENT ALLEGED IN SUMMONS & COMPLAINT ______________________________

PATIENT'S NAME **LAST** ______________________ **FIRST/MI** ______________________ **DOB** ______________

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)*

DATE OF SERVICE ______________________________________

MANNER OF SERVICE/to whom (i.e. mail, personal delivery) ______________________

❑ **AN OCCURRENCE**
❑ **ATTORNEY'S REQUEST LETTER**
❑ **OTHER** *(specify)* ______________________________________

NOTICE OF CLAIM FORM COMPLETED BY: ______________________________ ______________________

PRINT NAME **DATE**

PLEASE MAIL THIS FORM WITH COPIES OF DOCUMENTS VIA MAIL, CERTIFIED/RETURN RECEIPT REQUESTED, TO:

HEALTHCARE PROFESSIONALS INSURANCE COMPANY
ATTN: Claims Department
217 GREAT OAKS BLVD.
ALBANY, NY 12203-5964