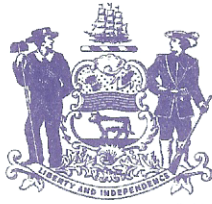


State of Delaware



MATTHEW DENN
INSURANCE COMMISSIONER

841 SILVER LAKE BLVD.
DOVER, DELAWARE 19904-2465
(302) 739-4251
FACSIMILE (302) 739-5280

Department of Insurance

DOMESTIC/FOREIGN INSURERS BULLETIN NO. 18 MEDICAL NEGLIGENCE INSURANCE CLAIMS REPORTING

ISSUED: July 20, 2005

On July 7, 2005, House Bill 133 became effective as 75 *Del. Laws* Ch. 109. The law amends Delaware's medical negligence insurance litigation law by rewriting the reporting requirements for insurers settling or paying claims on medical negligence actions.

The changes to the reporting requirements in 18 *Del. C.* § 6820 now require that insurers paying any amount for insurance coverage under a medical malpractice/negligence policy shall, within sixty (60) days following final disposition of the case by agreement, settlement, order, adjudication, or otherwise, file a report with the Delaware Department of Insurance which shall include the following information:

- The name of the insured.
- A detailed statement of the medical negligence claim asserted against the insured.
- A statement detailing the result or final disposition of the claim against the insured, including disclosure of the manner of the resolution or disposition of such claim, the amount ordered, adjudged or agreed to be paid by or on behalf of the insured, the amount paid by such insurance carrier on behalf of the insured as part of that settlement, adjudication or order and the total amount paid by such insurance carrier for attorney's fees, costs and expenses incurred on behalf of the insured.

The form approved by the Delaware Department of Insurance and the Delaware Board of Medical Practice is attached and shall be used by all insurers submitting reports required by 18 *Del. C.* § 6820. Insurers shall provide a copy of the completed form to each insured party to the claim. Insurers are permitted to modify the form to provide for non-substantive recurring or routine information such as company name and contact information, claim prefix or suffix designators, etc. The form is available online and can be downloaded for form modification and use at <http://www.state.de.us/inscom/default.shtml>.



Matthew Denn
Insurance Commissioner

REPORT OF DELAWARE MEDICAL NEGLIGENCE CLAIMS 18 Del. C. § 6820

(PLEASE TYPE OR PRINT CLEARLY)

TO: Delaware Insurance Department
Attn: Shirley L. Davis
841 Silver Lake Blvd.
Dover, De 19904
(302) 674-7317 Fax (302) 739-6278 or Direct E-Fax (302) 736-7972

FROM: Insurer's Name: _____
Insurer's NAIC No.: _____
Insurer's Address: _____

Insurer's Telephone No.: _____

1. INSURED PERSON OR ENTITY

Name: _____
Professional affiliation, if any: _____
Business Address: _____

Business Telephone: _____
Field or Specialty: _____
Delaware License No.: _____

2. CLAIMANT

Name(s): _____
Claim No.: _____

3. CIVIL SETTLEMENT WITHOUT LAWSUIT

If this claim was settled without a lawsuit being filed, please provide the following information:

- A. Was payment made to the claimant: Yes _____ No _____
- B. Date of settlement _____
- C. Date claim closed _____
- D. Amount of insurer's payment to Claimant excluding attorneys fees \$ _____
- E. Amount of insurer's legal fees and non-medical costs related to the claim \$ _____
- F. If more than one person or entity contributed to the settlement:
 - The full amount of settlement \$ _____
 - The full amount of legal fees and non-medical costs related to the claim irrespective of whether the claimant received any payment \$ _____

- Names of other parties to the settlement

4. SETTLEMENT OR JUDGMENT RESULTING FROM LAWSUIT

If this claim was settled or adjudicated after the filing of a lawsuit, please provide the following information:

A. Court name (including state/county in which filed) _____

B. Name(s) of Plaintiff(s) other than Claimant _____

C. Name(s) of Defendant(s) other than insured _____

D. Docket Number _____

E. Disposition Settlement _____ Verdict _____
 in favor of: Claimant _____ Insured _____ Other _____

F. Date of disposition _____

G. If the disposition was in favor of the Claimant:

Total amount of settlement/verdict excluding insured's legal fees and related non-medical costs \$ _____

Total amount of insured's legal fees and related non-medical costs irrespective of whether the Plaintiff received any payment
 \$ _____

H. Total amount paid by and/or attributable to insured for settlement/verdict, legal fees and non-medical costs irrespective of whether the Plaintiff received any payment
 \$ _____

5. DESCRIPTION OF THE CLAIM

Please provide a detailed description of the claim in general and the specific allegations against the insured. _____

6. NOTICE TO THE INSURED

Has the insured been provided with a copy of this form: Yes _____ No _____

Date this notice was provided to insured: _____

Except as otherwise required by law, information reported on this form to the Commissioner shall be kept confidential, shall not be subject to disclosure to the public pursuant to the Freedom of Information Act (29 Del. C. Chapter 100) or for any other reason, and shall not be subject to subpoena or any other legal process.

Rev 7/19/05 Approved by the Board of Medical Practice 7/19/05