Trinidad Navarro
Commissioner

Delaware Department of Insurance

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

Issued: July 20, 2005
Revised: March 28, 2017

Delaware's medical negligence insurance litigation law at 18 **Del C.** § 6820, in effect since July 7, 2005, sets forth reporting requirements for insurers settling or paying claims on medical negligence actions.

The **purpose of the revisions to this bulletin** is to clarify that the form that Insurers are to use to fulfill their reporting requirements under 18 **Del C.** § 6820 is attached to this bulletin as a Word© fillable document that may be downloaded from the Department's Bulletins webpage at http://insurance.delaware.gov/information/bulletins/.

Insurers paying any amount for insurance coverage under a medical malpractice/negligence policy are required to, 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 pain by such insurance carrier for attorney's fees, costs and expenses incurred on behalf of the insured.

The attached form has been approved by the Delaware Department of Insurance and the Delaware Board of Medical Practice 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.

Any questions, comments or requests for clarification about this bulletin should be emailed to consumer@state.de.us.

This Bulletin shall be effective immediately and shall remain in effect unless withdrawn or superseded by subsequent law, regulation or bulletin.

Trinidad Navarro
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.