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