

**MEDICAL INCIDENT OR THREAT OF CLAIM FORM  
FOR PHYSICIAN, SURGEON, DENTIST & PODIATRIST APPLICATIONS**

**APPLICANT'S INSTRUCTIONS:**

- 1. Answer all questions. If the answer requires detail, please attach a separate sheet.
- 2. This is a mandatory form which must accompany a completed application and supplemental claim information form.
- 3. PLEASE READ THE STATEMENTS AT THE END OF THIS APPLICATION CAREFULLY.  
(PLEASE TYPE OR PRINT IN INK)

**1. NAME OF APPLICANT**

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**2. APPLICANT HISTORY**

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- a. Are you aware of any act, error, omission or circumstance which could result in a malpractice claim or suit being made against you? .....[ ] Yes [ ] No  
If Yes, has this been reported to a prior carrier? .....[ ] Yes [ ] No  
**SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such medical incident or threat of claim; have you attached the completed form?.....[ ] Yes [ ] No**
- b. To the best of your knowledge, have any of the following adverse results occurred in your practice in the last (5) years:
  - (i) Unexpected death (including stillbirths)? .....[ ] Yes [ ] No
  - (ii) Unexpected organ failure or significant neurological or functional deficit? .....[ ] Yes [ ] No
  - (iii) Failure to diagnose cancer or infection resulting in death or disability of patient? .....[ ] Yes [ ] No
  - (iv) Tear or perforation of an organ or body part during an invasive procedure, or unplanned removal of a normal organ or body part during an operative procedure? .....[ ] Yes [ ] No
  - (v) Suspicious or positive x-ray, Pap smear or mammogram where patient was not contacted? .....[ ] Yes [ ] No
  - (vi) Follow-up/emergency surgery, myocardial infarction or cerebral vascular accident within **48 hours** of your previous diagnostic treatment or surgery? .....[ ] Yes [ ] No
  - (vii) Complications from improper medication or improper dosage?.....[ ] Yes [ ] No
  - (viii) Pathological and/or operative report which do not match? .....[ ] Yes [ ] No
 If yes to any of the above, has it been reported to a prior carrier?.....[ ] Yes [ ] No  
**If you have NOT reported to a prior carrier, please attach an explanation.  
SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such adverse result; have you attached the completed form? .....[ ] Yes [ ] No**
- c. Has any attorney contacted you (e.g., request for medical records) in connection with any patient that has NOT been disclosed to us? .....[ ] Yes [ ] No  
If yes, **SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such adverse result; have you attached the completed form?.....[ ] Yes [ ] No**
- d. Does your current professional liability carrier require reporting of an incident or request for records by a patient or attorney? .....[ ] Yes [ ] No
- e. Has any prior professional liability carrier refused coverage for, or declined to accept your report of, a medical incident, threat of claim, adverse result or attorney contact? .....[ ] Yes [ ] No  
If yes, please attach an explanation.

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same warranty and conditions.

\_\_\_\_\_  
Name of Applicant\*

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete the insurance.