CLAIMS INFORMATION FORM

PLEASE MAKE COPIES OF THIS PAGE AS NEEDED FOR ADDITIONAL CLAIMS YOU ARE REPORTING TO FAIRWAY.

NOTE: THIS **CLAIMS INFORMATION FORM** PERTAINS TO LAWSUITS, CLAIMS OR DEMANDS FOR ARBITRATION **OR** INCIDENTS WHICH COULD LEAD TO CLAIMS. A CLAIMS FORM ***MUST*** BE COMPLETED FOR EACH LAWSUIT, CLAIM, DEMAND FOR ARBITRATION OR INCIDENT. SUFFICIENT INFORMATION MUST BE PROVIDED TO EVALUATE THE MEDICAL ASPECTS OF THE CASE SPECIFICALLY RELATING TO THE PHYSICIAN'S INVOLVEMENT.

1. PATIENT'S NAME: ______________________ **2. AGE:** _____ **3. SEX (M/F):** _____

4. YOUR RELATIONSHIP TO PATIENT (I.E. ATTENDING PHYSICIAN, PRIMARY SURGEON, ASST. SURGEON, ETC)**:**

____

5. DATE OF INCIDENT: ____/____/____ **6. LOCATION:** ______________________

7. INSURANCE CARRIER: ______________________ **8. OTHER DEFENDANTS:** ______________________

____

9. PRESENT STATUS: q OPEN q CLOSED ____/____/____ DATE ______________________

q INCIDENT ONLY q 90-DAY NOTICE q SUIT FILED q SUIT SERVED q ARBITRATION

METHOD OF CLOSING: q DISMISSED q DEFENSE VERDICT

q SETTLED AMOUNT PAID ON YOUR BEHALF: $ __________ TOTAL SETTLEMENT: $ __________

q JUDGMENT AMOUNT PAID ON YOUR BEHALF: $ __________ TOTAL SETTLEMENT: $ __________

THE FOLLOWING QUESTIONS SHOULD BE ANSWERED IN EXPLICIT CLINICAL DETAIL TO ALLOW PROPER EVALUATION BY THE FAIRWAY UNDERWRITING DEPARTMENT. ATTACH ADDITIONAL SHEETS AS REQUIRED.

10. PATIENT'S ALLEGIATIONS OR CIRCUMSTANCES BROUGHT TO YOUR ATTENTION: ______________

____

11. CONDITION AND DIAGNOSIS AT TIME OF INCIDENT: ______________________

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12. DATES AND DESCRIPTION OF TREATMENT RENDERED: ______________________

____

____

13. CONDITION OF PATIENT SUBSEQUENT TO TREATMENT (AND DATES OF FOLLOW-UP TREATMENT):

____

____

I UNDERSTAND INFORMATION SUBMITTED HEREIN BECOMES PART OF THE FAIRWAY'S NAMED INSURED'S RECORDS.

____/____/____ ______________________________
DATE PHYSICIAN'S NAME (PLEASE PRINT)

____
PHYSICIAN'S SIGNATURE

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