STAR INSURANCE COMPANY

Home Office: Southfield, Michigan

CLAIMS INFORMATION SUPPLEMENTAL APPLICATION

NOTE: A separate form must be completed for each claim or suit reported.

Name of Applicant:

1. Name:	Age	Sex of patient:	2. Date of first consultation:

3. Physical condition and diagnosis at the first consultation date above: (Please Explain)

4. Brief description of treatment leading to allegation, including dates of treatment given and nature of same (Explain):

5. Allegations made against you (Explain):

6. Date of Incident:	7. Date you received notice of claim:

8. Subsequent condition or health of patient:

9. Current status of claim:

☐ **OPEN** ☐ **CLOSED** Date:_____

Lawsuit filed? ☐ Yes ☐ No ☐ Dismissed ☐ Judgment ☐ Settled

Amount of claimant's demand: $ _____ Total amount paid on claim: $ _____

Amount paid on your behalf: $ _____

10. Did you report this claim: ☐ Yes ☐ No	11. If yes, what insurance company was involved:

12. Name(s) of other defendants:

13. To whom may we refer for further information about this claim:

I declare that the information submitted herein is true and accurate. I understand that it becomes a part of my Professional Liability Application.

_____ _____

Signature of Applicant *Date*

_____ _____

Signature of Agent *Date*