



### Prior Claim/Suit Information Addendum

This addendum is to be completed for each claim/suit made against you in the past ten years. Additional documentation may be required by MMIC upon receipt of this information.

Name of Applicant:	MMIC Policy Number (if applicable):
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#### Claim/Suit Information

Claimant Full Name:	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date(s) of treatment and/or surgery, which led to the allegations against you:		
Nature of the allegations in the claim or suit:		
Was suit ever filed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when was it filed?	
Name of other doctor(s) and hospital(s), if any, involved in claim/suit:		
Disposition or current status of claim or suit: <input type="checkbox"/> Open <input type="checkbox"/> Closed		
If open, indicate case value established by carrier:	If closed, was payment made? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If claim is not closed, was claim or suit withdrawn? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If payment was made, indicate total amount of settlement or award:		
How much was paid on your behalf:		
Name of insurance carrier defending you:		

Provide a complete narrative description of the **medical** facts. Please include the type of treatment and/or surgery and your involvement. **Please give as complete a narrative description as possible.**

**Claim/Suit Information**Claimant Full Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Date(s) of treatment and/or surgery, which led to the allegations against you: \_\_\_\_\_

Nature of the allegations in the claim or suit: \_\_\_\_\_

Was suit ever filed?  Yes  No \_\_\_\_\_ If yes, when was it filed? \_\_\_\_\_

Name of other doctor(s) and hospital(s), if any, involved in claim/suit: \_\_\_\_\_

Disposition or current status of claim or suit:  Open  ClosedIf open, indicate case value established by carrier: \_\_\_\_\_ If closed, was payment made?  Yes  NoIf claim is not closed, was claim or suit withdrawn?  Yes  No

If payment was made, indicate total amount of settlement or award: \_\_\_\_\_

How much was paid on your behalf: \_\_\_\_\_

Name of insurance carrier defending you: \_\_\_\_\_

Provide a complete narrative description of the **medical** facts. Please include the type of treatment and/or surgery and your involvement. **Please give as complete a narrative description as possible.**

**Claim/Suit Information**Claimant Full Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Date(s) of treatment and/or surgery, which led to the allegations against you: \_\_\_\_\_

Nature of the allegations in the claim or suit: \_\_\_\_\_

Was suit ever filed?  Yes  No \_\_\_\_\_ If yes, when was it filed? \_\_\_\_\_

Name of other doctor(s) and hospital(s), if any, involved in claim/suit: \_\_\_\_\_

Disposition or current status of claim or suit:  Open  ClosedIf open, indicate case value established by carrier: \_\_\_\_\_ If closed, was payment made?  Yes  NoIf claim is not closed, was claim or suit withdrawn?  Yes  No

If payment was made, indicate total amount of settlement or award: \_\_\_\_\_

How much was paid on your behalf: \_\_\_\_\_

Name of insurance carrier defending you: \_\_\_\_\_

Provide a complete narrative description of the **medical** facts. Please include the type of treatment and/or surgery and your involvement. **Please give as complete a narrative description as possible.**