PROFESSIONALS' INSURANCE AGENCY, INC.
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MEDICAL INCIDENT OR THREAT OF CLAIM FORM

Applicable to Oral and Maxillofacial Surgeons Application, and Supplemental Claim Information Form

This is a mandatory form which must accompany your completed application and supplemental claim information form, if applicable.

1. 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

A SUPPLEMENTAL CLAIM INFORMATION FORM is required for each such medical incident or threat of claim; have you attached the completed form? ☐ Yes ☐ No

2. To the best of your knowledge, has any of the following adverse results occurred in your practice in the last 5 years including, but not limited to:

a.	Unexpected death?	☐ Yes	☐ No
b.	Unexpected organ failure or any significant neurological or functional deficit?	☐ Yes	☐ No
c.	Any failure to diagnose cancer or infection resulting in death or disability of patient?	☐ Yes	☐ No
d.	Any tear or perforation of an organ or body part during any invasive procedure, or unplanned removal of a normal organ or body part during any operative procedure?	☐ Yes	☐ No
e.	Any suspicious or positive X-ray where patient was not contacted?	☐ Yes	☐ No
f.	Follow-up emergency surgery, myocardial infarction or cerebral vascular accident within 48 hours of your previous diagnostic treatment or surgery?	☐ Yes	☐ No
g.	Any complication from improper medication or an improper dosage?	☐ Yes	☐ No
h.	Any pathological and/or operative report which does 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, attach an explanation.

A SUPPLEMENTAL CLAIM INFORMATION FORM is required for each such adverse result; have you attached the completed form? ☐ Yes ☐ No

3. Have you had any attorney contact (e.g., request for medical records) involving any patient that has NOT been disclosed to us? ☐ Yes ☐ No

If yes, a SUPPLEMENTAL CLAIM INFORMATION FORM is required for each such attorney contact; have you attached the completed form? ☐ Yes ☐ No

4. Does your current professional liability carrier require reporting of an incident or request for records by a patient or attorney?
☐ Yes ☐ No ☐ Uncertain

5. 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, 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.

Signature of Applicant_____ Date_____