REPORT OF DELAWARE MEDICAL NEGLIGENCE CLAIMS 18 *Del. C.* § 6820

(PLEASE TYPE OR PRINT CLEARLY)

TO: Delaware Insurance Department
1351 West North St. Suite 101
Dover, DE 19904
Email: medmal@delaware.gov

FROM: Insurer's Name:_____
Insurer's NAIC No.:_____
Insurer's Address:_____
_____
_____
Insurer's Telephone No.:_____

1. INSURED PERSON OR ENTITY

Name:_____
Professional affiliation, if any:_____
Business Address: _____
_____
_____
Business Telephone: _____
Field or Specialty: _____
Delaware License No.: _____

2. CLAIMANT

Name(s):_____
Claim No.: _____

3. CIVIL SETTLEMENT WITHOUT LAWSUIT

If this claim was settled without a lawsuit being filed, please provide the following information:

A. Was payment made to the claimant: Yes_____No_____
B. Date of settlement _____
C. Date claim closed _____
D. Amount of insurer's payment to Claimant excluding attorneys' fees $_____
E. Amount of insurer's legal fees and non-medical costs related to the claim $_____
F. If more than one person or entity contributed to the settlement:
   - The full amount of settlement $_____
   - The full amount of legal fees and non-medical costs related to the claim irrespective of whether the claimant received any payment $_____

- Names of other parties to the settlement

  _____

  _____

4. SETTLEMENT OR JUDGMENT RESULTING FROM LAWSUIT

If this claim was settled or adjudicated after the filing of a lawsuit, please provide the following information:

A. Court name (including state/county in which filed)_____
B. Name(s) of Plaintiff(s) other than Claimant _____

   _____
C. Name(s) of Defendant(s) other than insured _____

   _____
D. Docket Number _____
E. Disposition Settlement_____Judgment_____
   in favor of: Claimant_____Insured_____ If Other, please provide specific details (i.e. other named-defendants, etc.)_____
   against: Insured_____ If Other, please provide specific details (i.e. other named-defendants, etc.)_____
F. Date of disposition _____
G. If the disposition was in favor of the Claimant:
   - Total amount of settlement/judgment excluding insured's legal fees and related non-medical costs $_____
   - Total amount of insured's legal fees and related non-medical costs irrespective of whether the Plaintiff received any payment $_____
H. Total amount paid by and/or attributable to insured for settlement/judgment, legal fees and non-medical costs irrespective of whether the Plaintiff received any payment $_____
I. If resolved by settlement, names of the parties to the settlement

   _____

   _____

5. DESCRIPTION OF THE CLAIM

Please provide a detailed description of the claim in general and the specific allegations against the insured. _____

_____

_____

_____

_____

6. NOTICE TO THE INSURED

Has the insured been provided with a copy of this form: Yes_____No _____
Date this notice was provided to insured:_____

Except as otherwise required by law, information reported on this form to the Commissioner shall be kept confidential, shall not be subject to disclosure to the public pursuant to the Freedom of Information Act (29 Del. C. Chapter 100) or for any other reason, and shall not be subject to subpoena or any other legal process.