ISMIE Mutual Insurance Company
The Physician-First Service Insurer

ATTN: UNDERWRITING DIVISION

Twenty North Michigan Avenue
Suite 700
Chicago, IL 60602
Telephone 312-782-2749
Toll Free 800-782-4767
Fax 312-782-2023
www.ismie.com

BR-3900-NC (11/19)

Processing Number _____

Application for Non-Physician Professional Liability Insurance

□ Separate Limits
□ Shared Limits*

Please choose your desired coverage option either claims-made or occurrence. It is important for you to discuss which coverage type to apply for with your ISMIE insured employer prior to submitting an application to ISMIE. The type of coverage you can obtain will typically match your employer's coverage.

Claims-Made Coverage ☐

"A claims-made policy is limited to claims which are first made while the policy is in force and arise out of professional services provided on or after the retroactive date stated in the Declarations page, and as defined in the policy."

Occurrence Coverage ☐ (Not Available in Texas)

"An occurrence policy is limited to claims that arise out of professional services rendered during the policy period stated in the Declarations Page and as defined in the policy."

Instructions: This application should be completed by Allied Health Personnel including: Certified Registered Nurse Anesthetists, Certified Clinical Nurse Specialists, Certified Nurse Practitioners, Certified Nurse-Midwifes, Physician Assistants and Psychologists, as well as Dentists, Optometrists and Pharmacists. An Individual Physician application is required for Chiropractors and Podiatrists. It is essential that all statements be completed and all questions answered. If the answer to any question is "**no**", be certain to check "**no"** on the Application. **Please do not leave any question unanswered. If additional space is required to answer any question, use the "Remarks Addendum" section. *Only separate limits are available in states with a Patient Compensation Fund.**

1. Applicant Name:

First Middle Last Title

☐ Male ☐ Female

2A. Name of ISMIE Mutual Insured Employer:

Name Policy Number

2B. Indicate all states of practice where ISMIE Mutual coverage is desired:

3. Desired effective date of coverage (12:01 a.m. Standard Time):

Month Day Year

4. Desired retroactive date for Claims-Made coverage (for prior acts coverage only - 12:01 a.m. Standard Time)
Retroactive date is required to secure prior acts coverage (nose coverage). ***Applicable to separate limits only*:**
***only applicable for Claims-Made Coverage, leave blank if applying for Occurrence Coverage**

Month Day Year

Non-Physician General Information

5. Date of Birth: _____ **6. Social Security Number:**_____

7. Home Address: _____

_____

City: **State:** **Zip Code:**

Telephone: ( ) - Fax: ( ) - E-Mail Address:

8 a. Professional Designation (i.e. Nurse Practitioner, Certified Nurse Midwife, etc.)**:**_____
Please provide a copy of your current job description; and provide a copy of your collaborative agreement(s) (if applicable).

8 b. License Number:_____
(include copy of license) State:_____

8 c. Professional Certification(s):_____

9 a. Mailing Address:
Note: This address is where all of your insurance documents and correspondence will be sent.

Address Line l:

Address Line 2:

City: **State:** **Zip Code:** **Telephone: ( ) -**

Fax: ( ) - **E-mail Address:**

9 b. Billing Address: **Same as 9a.** ☐
Note: This address is where all of your insurance premium invoices and notices will be sent.

Address Line l:

Address Line 2:

City: **State:** **Zip Code:** **Telephone: ( ) -**

Fax: ( ) - **E-mail Address:**

10. Previous Insurance Carriers - Last five (5) years:*

Carrier Name	Policy Period	Limits	Claims-Made	Occurrence
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

***It is necessary that you obtain a current Loss History from each carrier listed above.**

11. Training Completed:_____ Year Graduated:_____

Name of Facility/Institution

_____ Degree:_____

City State Country

12. A. Additional Training
Name of Hospital/Facility:

_____

_____

City State Country

Type of Training:_____

From: _____ To: _____

mo./yr. mo./yr.

Completed: ☐ Yes ☐ No

B. Additional Training
Name of Hospital/Facility:

_____

_____

City State Country

Type of Training:_____

From: _____ To: _____

mo./yr. mo./yr.

Completed: ☐ Yes ☐ No

13. Previous Professional Experience since Completion of Formal Training

City, State, Country	From Month /Year	To Month/Year	Practice Activity/ Employer	Carrier

14. Policy Limits (Please skip this section if you practice in a state with a Patient's Compensation Fund)

❑ $1,000,000/$3,000,000 "each person"/ "aggregate"	❑ $2,000,000/$4,000,000 "each person"/ "aggregate"

(will be separate from your employer's, but must be equivalent to your employer's)

☐ Shared Limits (will be shared with your employer)

15. Practice Information

List all current Office/Outpatient Practice Locations in this section. Include all locations whether or not ISMIE Mutual insurance is desired at that location. Please indicate additional locations on the "Remarks Addendum" section. Please include facility code(s) to identify all that are applicable.

Facility Codes (Please indicate all that apply)

01- Physician Office
02- Hospital
03- Extended Hour Walk-In Clinic
04- Surgicenter
05- Day Spa / Medi-Spa
06- Nursing Home/Extended Care Facility
07-HMO, IPA, PPO
08-Urgent Care Center
09-Clinic with overnight stays
10-Industrial Clinic
11- Government Location
12-Weight Reduction Clinic
13-Pharmacy
14-Abortion Clinic
15-Drug Control Clinic
16-Commercial Laboratory
17-Other

A. Office Name: _____

Facility Code: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____

Is this your primary office location? **Yes** ☐ **No** ☐

Distance from Home: **Miles** _____ **Minutes** _____

Do you own or operate a Pharmacy at this location? Yes ☐ **No** ☐

If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance.

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

If "No," describe activity not to be covered and state by whom insured:

_____

_____

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.**

_____.

B. Office Name: _____

Facility Code: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____

Is this your primary office location? **Yes** ☐ **No** ☐

Distance from Home: **Miles** _____ **Minutes** _____

Do you own or operate a Pharmacy at this location? Yes ☐ **No** ☐

If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance.

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

If "No," describe activity not to be covered and state by whom insured:

_____

_____

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.**

_____.

16. Do you maintain hospital privileges at one or more facilities? Yes ☐ No ☐
If yes, please complete section A and B (please copy this page for additional hospital locations)
If you do not maintain hospital privileges, please explain in the "Remarks Addendum" section.

A. Hospital Name: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____ **Fax:** _____

Category of privileges (active, consulting, etc.) _____

Specialty department of: _____

Do you teach at this hospital? **Yes ☐ Classroom ☐ Clinical ☐**

Do you provide services in the ER at this hospital?

Yes ☐ No ☐

If "Yes", average number of hours weekly: _____

Is this location a Nursing Home or Extended Care Facility?

Yes ☐ No ☐

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ No ☐

If "no," describe activity not to be covered and state by whom insured:

_____

Is this your primary hospital location?: Yes ☐ No ☐

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, etc.**

Distance from Home: **Miles** _____ **Minutes** _____

B. Hospital Name: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____ **Fax:** _____

Category of privileges (active, consulting, etc.) _____

Specialty department of: _____

Do you teach at this hospital? **Yes ☐ Classroom ☐ Clinical ☐**

Do you provide services in the ER at this hospital?

Yes ☐ No ☐

If "Yes", average number of hours weekly: _____

Is this location a Nursing Home or Extended Care Facility?

Yes ☐ No ☐

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ No ☐

If "no," describe activity not to be covered and state by whom insured:

_____

Is this your primary hospital location?: Yes ☐ No ☐

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, etc.**

Distance from Home: **Miles** _____ **Minutes** _____

17. Describe practice activities, including any procedures performed:

18. Profile Questions (Include details to each question in the "Remarks Addendum.")

YES	NO	
☐	☐	a. Has your professional liability insurance ever been canceled for non-payment, declined, non-renewed, or issued on terms (including, but not restricted to: restrictive endorsements, surcharged premium, other underwriting action etc.)? **(Not Applicable in Missouri)**
☐	☐	b. Have you treated any patients by means of any therapeutics which could be considered unconventional, experimental, investigational or clinical research that is not within the scope of research protocols approved by the Food and Drug Administration (FDA) or an institutional review board (IRB) (also known as an independent ethics committee (IEC), an ethical review board (ERB) or a research ethics board (REB))? If "Yes", utilize the "Remarks Addendum" on page 11 to provide a full written narrative indicating treatment(s), and provide name(s) and address(es) of sponsoring institution(s) or entity(ies) if applicable.
☐	☐	c. Have any of your hospital privileges ever been denied, modified, suspended, revoked, non-renewed or accepted on a restricted basis or have you ever been subjected to probation, reprimand, censure, sanction or other disciplinary action as a result of a hospital committee investigation or inquiry?
☐	☐	d. Have you ever been subjected to probation, suspension, reprimand, censure, sanction or other disciplinary action as a result of any governmental agency, medical or professional society disciplinary or administrative proceedings?
☐	☐	e. Has membership in any medical society or professional organization ever been denied, suspended, revoked, voluntarily surrendered or accepted on a restricted basis?
☐	☐	f. Have you ever been convicted of an act committed in violation of any law, statute or ordinance, including a conviction for driving while intoxicated (DUI), excluding other traffic offenses?
☐	☐	g. Has your license to practice medicine or prescribe controlled substance ever been suspended, revoked, voluntarily surrendered, reprimanded, fined or subjected to probationary terms? If "Yes", indicate which:
☐	☐	h. Have you ever incurred, become aware of having, or had an allegation made against you of having any illness or physical disability that impairs or potentially could impair your ability to practice medicine or your specialty including but not limited to: alcoholism, substance abuse, mental illness, degenerative diseases of the central nervous system, organic brain disease, convulsive disorders, multiple sclerosis, rheumatoid arthritis, infectious disease, etc.?
☐	☐	i. Has any malpractice claim or suit been brought against you within the past five (5) years? If "Yes", please complete the Claim Information Supplement for each claim/suit brought against you in the past and submit complete copies of all office/hospital records, summons and complaint, etc.

Certificate(s) of Insurance

19. If your insurance request is accepted, as a service to its members, ISMIE Mutual can provide evidence of your coverage on an automated basis to a hospital, employer, etc. by issuing a Certificate of Insurance. If you wish to have a Certificate of Insurance issued to a **third party**, please complete the following:

Name of Certificate Holder

Street Address

City **State** **Zip**

Please check one:

- ☐ **Medical Director**
- ☐ **Medical Staff Office**
- ☐ **Administrator**
- ☐ **Other** _____

Specific Policy Limits will be printed on Certificate.

Name of Certificate Holder

Street Address

City **State** **Zip**

Please check one:

- ☐ **Medical Director**
- ☐ **Medical Staff Office**
- ☐ **Administrator**
- ☐ **Other** _____

Specific Policy Limits will be printed on Certificate.

Applicant's Representation, Authorization and Release

(Please read carefully)

ELECTRONIC SIGNATURES ARE PERMISSIBLE PURSUANT TO THE ELECTRONIC COMMERCE SECURITY ACT (5 ILCS 175)

PROXY

By applying for and receiving coverage from ISMIE Mutual Insurance Company, the policyholder/member agrees to grant, assign, and give a proxy to the Board of Directors of ISMIE Mutual Insurance Company or their designee, for purpose of casting a vote at any and all meetings or in any and all instances in which a vote of the policyholders/members is required. It is understood that in the absence of any further action by the policyholder/member, this proxy shall remain valid and binding for the length of time which the policyholder/member shall continue to be a policyholder/member of ISMIE Mutual Insurance Company. It is further understood that on any given issue as to which policyholders/members shall have a right to vote the policyholder/member may, by indicating in writing his, her, or its desire, revoke this proxy for purposes of the issue or matter then pending a vote. In the instance in which the policyholder/member revokes this proxy, he, she, or it may then vote in person or by written proxy at any meeting called for the casting of said vote. At the conclusion of said vote, this proxy, given to the ISMIE Mutual Board of Directors or its designee, shall return to full force and effect and shall continue in full force and effect unless and until the policyholder/member elects to revoke this proxy for purposes of a future issue which may arise.

_____	_____	_____
Applicant's Name (please print)	**Applicant's Signature**	**Date**

REPRESENTATION

I hereby represent that the information contained in this application and any supplementary submission is complete and true and that no material facts which are reasonably likely to influence the judgment of ISMIE Mutual in considering this application have been omitted. *I agree that this shall be the basis of the policy of insurance requested and that I will notify ISMIE Mutual of any changes contained herein.*

FRAUD NOTICES

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO ALABAMA APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

NOTICE TO ALASKA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

NOTICE TO ARIZONA APPLICANTS: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE TO ARKANSAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO CALIFORNIA APPLICANTS: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE TO DELAWARE APPLICANTS: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO IDAHO APPLICANTS: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

NOTICE TO INDIANA APPLICANTS: A person who knowingly and with intent to defraud and insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE TO LOUISIANA, NEW MEXICO AND RHODE ISLAND APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO NEW HAMPSHIRE APPLICANTS: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the state value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE TO PUERTO RICO APPLICANTS: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, will be sanctioned for each violation with a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty may be increased to a maximum of five (5) years, if attenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE TO TEXAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO WEST VIRGINIA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

HIPAA DISCLOSURE

ISMIE Mutual Insurance Company and its affiliates shall act as business associates of applicant(s) with respect to the receipt, use and disclosure of protected health information. The Business Associate Agreement is hereby incorporated by reference.

AUTHORIZATION

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, ISMIE Mutual or its duly authorized representative may conduct an inquiry or investigation of my professional background, qualifications and competence, including such other underwriting or claim matters as are deemed relevant for this insurance. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, my/their insurance agents or consultants, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any attending or treating physician, any prior insurance carriers and ISMIE Mutual, or its duly authorized representative. I hereby release and discharge the aforementioned providers of information, ISMIE Mutual, its duly authorized review committee from any and all legal liability which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by ISMIE Mutual or its duly authorized representative**.** I authorize ISMIE Mutual or its duly authorized representative to provide information regarding my professional liability history and to issue Certificates of Insurance to those hospitals, managed care entities or other organizations to which I am affiliated or have applied. I consent and agree to the exchange of information regarding my professional liability policy between my present/future employer and ISMIE Mutual or its duly authorized representative. In the event that my insurance premiums are paid by my present/future employer and the practice relationship between myself and my employer is severed at any time during the policy period for any reason, including but not limited to cancellation of my policy, it is agreed that any and all remaining insurance premiums, including any return premium due, as of the severance date of the practice relationship, shall be the property of the employer. Communication regulations require that certain entities, including ISMIE Mutual and its affiliates, obtain written consent to share or distribute policyholder information via regular mail, e-mail, and facsimile. By signing this consent and authorization, you are agreeing to receive promotional notices or solicitation of the availability of goods, services, membership, and opportunities related to the practice of medicine from ISMIE Mutual and its affiliates.

Applicant's Name (*please print*)	Applicant's Signature	Date
Employer's Name (*please print*)	Employer's Signature	Date

I understand that signature of this application does not bind ISMIE Mutual to complete processing of the application nor to offer insurance to the applicant. A photostatic, imaged or other electronic copy of this Representation, Authorization and Release shall be considered as effective and as valid as the original. PLEASE NOTE: Email transmission of a completed application or other document is unsecure. ISMIE Mutual is not responsible for any disclosure while the information is in transit. Email submissions may be made to underwriting@ismie.com

Insurance Agent/Producer/Broker (*please print*)	Signature	Date

Claim Information Supplement (please print).

In addition to completing this form, please provide a typed, detailed narrative for each open claim, or any claim that has closed with an indemnity payment. Please photocopy this form for additional claims.

1. Patient/Claimant

_____
Name **Age** **Sex**

2. Date(s) of treatment and/or surgery which led to the allegations against you: _____

3. Was suit ever filed? ☐ **Yes** ☐ **No** **If "Yes", state** _____ _____
Month **Year**

4. Name of insurance carrier defending you: _____

5. Policy Number: _____

6. Names of other doctors and hospitals, if any, involved in claim or suit: _____

_____

7. Disposition or current status of claim or suit:

☐ **Open - Indicate case value established by carrier $**_____

- Has carrier indicated desire to settle?

☐ **Yes** ☐ **No**

☐ **Closed-With no payment made** **Date** _____

☐ **Closed-With payment made. Indicate amount of settlement or award:**

a. Your policy $ _____ **Date** _____

b. Total (if additional defendants involved) $ _____

1. Patient/Claimant

_____
Name **Age** **Sex**

2. Date(s) of treatment and/or surgery which led to the allegations against you _____

3. Was suit ever filed? ☐ **Yes** ☐ **No** **If "Yes", state** _____ _____
Month **Year**

4. Name of insurance carrier defending you: _____

5. Policy Number:_____

6. Names of other doctors and hospitals, if any, involved in claim or suit: _____

_____

7. Disposition or current status of claim or suit:

☐ **Open - Indicate case value established by carrier $**_____

- Has carrier indicated desire to settle?

☐ **Yes** ☐ **No**

☐ **Closed-With no payment made** **Date** _____

☐ **Closed-With payment made. Indicate amount of settlement or award:**

a. Your policy $ _____ **Date** _____

b. Total (if additional defendants involved) $ _____

Remarks Addendum (please print)

Question Number	Remarks

BR-3900-NC (11/19)