MedPro RRG Risk Retention Group

DENTAL LOSS INFORMATION SUPPLEMENT

Please make copies if additional forms are needed.

Applicant's Name _____

Note: Additional documentation may be requested at the Company's discretion.

A. Is the matter related to [ ] A, [ ] B or [ ] C (if applicable) from the Loss Information Section? (Check only one)

B. Patient/Claimant Information:

_____ _____ _____

Last Name **First Name** **Age**

C. Date of treatment and/or surgery, which led, or could lead, to allegations against you: (MM/YYYY) _____

D. Date notice received (if applicable): (MM/YYYY) _____

E. Has this matter been reported to your current or former insurer? ☐ Yes ☐ No

If yes, date reported to your current or former insurer? (MM/YYYY) _____

Current or former insurer name _____

If no, please explain _____

F. Name of all other doctor(s), hospital(s) or health care provider(s), if any, involved:

_____

_____

G. Current status: ☐ Open ☐ Closed

If open, indicate dollar value established by insurer: $_____

If closed,

1. Date of closing (MM/YYYY): _____
2. Was a payment made? ☐ Yes ☐ No
   a. If yes, did you consent to the settlement? ☐ Yes ☐ No
   b. Total amount of settlement or award: $_____
   c. Total amount of settlement or award paid on your behalf: $_____

H. Nature of allegations or potential allegations:

Condition Treated _____

Treatment Provided _____

Alleged Negligence _____

Alleged Injury _____

Please provide a narrative description of all relevant facts, including but not limited to your involvement in the treatment and/or surgery:

_____

_____

_____

_____