INSTRUCTIONS FOR COMPLETING LIABILITY CLAIM REPORT

Please complete the applicable sections as completely as possible.

Email to: Research and Statistics Division
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REQUIRED fields are indicated with an asterisk (*) on the report form. These fields must be completed for the report to be accepted and avoid load failure.

Tab 1 (Report on Claim)

COMPANY AND CONTACT INFORMATION: Complete Sections I and II.

- **Section I** – Company Information
  - Name of Insurance Company, Insurance Company Address.

- **Section II** – Contact Information
  - First Name, Last Name, Title (claims representative, analyst, etc), Email and Phone Number should all be completed.

REPORT OF CLAIM:
The original Report of Claim section should be completed and filed after the insurer receives information that the insured's liability for malpractice is asserted by either an insured, a patient of an insured, or an attorney. **This report should NOT be submitted when the insurer is only notified of an incident that may give rise to a claim.**

Section III Claim Information includes the following items.

- Date of Report * - Should be the date the liability claim report is prepared by the insurer.
- Indication of Reopened Claim - If a claim that was closed with a report of disposition has reopened; Choose either yes or no from the dropdown box in Section III Claim Information on the Date of Report line.
- Claim Number * - Should be the numbering system the insurer employs to identify the claim against the insured. Each insured identified in the claim should be assigned a separate, distinct claim number to clearly identify it. A separate Report of Claim should be submitted for each insured identified in the claim and insured by the insurance company.
- Policy Number * - Policy number assigned to the insured.
- Classification of Risk - ISO or insurer code number for the insured's practice or specialty)
- Class Description or Specialty - The description assigned as part of the classification system for the insured's practice or specialty.
- Date of Occurrence* - Date given to you in notification of claim or liability
- Place of Occurrence* - This is the actual physical location where the occurrence took place, i.e. ABC Hospital, Dr. Doe's Office, emergency room, operating room, patient's room, etc.
- Date Claim Asserted* - This is the date the insurer receives a Notice of Claim or a letter from a lawyer or

other person representing the insured asserting a claim is being initiated.

- Amount of Claim (if known) - Please either indicate the dollar amount that the plaintiff has initially requested or indicate "open" if no amount has been stated. Do not enter loss reserve.
- Wrongful Death assertion - Please report whether a wrongful death claim has legally been asserted.
- Arbitration Agreement - This item must be provided as a separate attachment to the email, (PDF is preferred)
    - Indication if an arbitration agreement has been filed.
- Professional License Number – This number is assigned by a Maine Professional Licensing Board
- Professional Licensee Type* - Medical Doctor (MD), Doctor of Osteopath (DO), or Physician's Assistant (PA), a Facility etc. (choose from dropdown box).

SECTION IV INSURED'S INFORMATION: * (Entire section required)

Information relating to the insured. If a hospital, nursing home or other healthcare facility, it should give the actual name of the facility. This name may be followed on the title line with the name of the corporation if available.

- First Name
- Last Name
- Title
- Affiliation
- Address 1
- Address 2 (if an additional line is needed. This line will ***not*** cause a load failure if blank)
- City, State, Zip Code
- Description of Occurrence - This information should be as brief and understandable as possible. It should clearly state the allegation against the insured. If there is not enough room for the description, continue in the comment section.
    - Enter a description of the circumstances causing the claim to rise to assertion. The description box accommodates 250 characters.

Tab 2. (Additional Insureds Identified in Claim)

Additional Insured(s) and Claim Number(s): - We would like to receive this information as soon as it is available to you. Please indicate the name of any insured(s) that are additionally identified in the Notice of Claim, whether the named physician is an MD, DO, PA, Dentist, Podiatrist, Hospital or other health care provider and provide their claim numbers. Please also list any entities that are not insured by your company and that are listed in the claim. For these persons who are not insured by your company, fill in "other insurer." If there is not room in the space provided to list all additional insureds identified in the claim, you may use the comment section or you may list that information on a separate page and attach it to the Claim Report. Separate Claim Reports need to be filed for each additional insured identified in the claim and in the Report of Disposition.

Tab 3. (Report on Disposition)

REPORT OF CLAIM DISPOSITION:

The Report of Claim Disposition should be completed and filed within 60 days of the disposition. A Report of Disposition is required when there is a final judgment or award to the claimant, a settlement involving payment of money or services, or a final disposition not involving any payment of money or services. Dismissal is by action of a Court or Judge.

The first portion of the disposition is automatically completed from the Report on Claim tab. These fields are locked and shaded gray. Fields available for completion are shaded yellow.

- Date of Report: This should be the date the liability claim disposition report is prepared by the insurer.
- Reopened Disposition: Choose Yes or No from the dropdown box (if you indicate yes, complete the last tab Reopened Disposition).
- Date Suit Filed or Arbitration Demanded: The date of suit, if filed or arbitration if demanded
- Docket Number: Docket Number assigned by the court.
- Reviewed By Pre-litigation Screening Panel: Choose Yes or No from the dropdown list. If "No" Choose from the dropdown list in the "Choose from List" box.

Screening Panel Pre-litigation Outcome:

- Panel Decision Date: Date the screening panel arrived at their decision.
- Outcome of Pre-litigation Screening Panel - Please fill in the number of panel members who voted yes and the number of panel members who voted no on the three findings listed.
- Case Dismissed by Panel Chair: If the case was dismissed by the panel chair for whatever reason as outlined in Title 24 M.R.S.A § 2853, please choose yes or no from the dropdown list.
- Reason for Disposition: Choose from dropdown list. If choosing "Other" use the comment section to explain the reason.

Date of Settlement, Judgment, Award, or Closing of File: If there is a date of settlement, judgment, or award, please use this date. If not, then please use the date the file closed.

Amount of Award/settlement: If none, mark $0.00. This refers only to the award, judgment or settlement against the insured in Report of Claim.

Allocated Claims Expense: If none, mark $0.00.

Tab 4. (Reopened Disposition)

REPORT OF RE-OPENED CLAIM DISPOSITION:

The Report of Claim Disposition should be completed and filed within 60 days of the disposition. A Report of Disposition is required when any claim that was the subject of a Report of Claim results in 1) a final judgment or award to the claimant in any amount; 2) a settlement involving payment in any amount of money or services; or 3) a final disposition not involving any payment of money or services. Please note that a judgment or award is final when it cannot be appealed, and a disposition is final when it results from judgment, dismissal, withdrawal or abandonment.

The first portion of the disposition is automatically completed from the Report on Claim tab. These fields are locked and shaded gray. Fields available for completion are shaded yellow.

- Date of Report: This should be the date the liability claim disposition report is prepared by the insurer.
- Reopened Disposition: Choose Yes or No from the dropdown box (if you indicate yes, complete the last tab Reopened Disposition).
- Date Suit Filed or Arbitration Demanded: The date of suit, if filed or arbitration if demanded.
- Docket Number: Docket Number assigned by the court if suit was filed
- Reviewed By Pre-litigation Screening Panel: Choose Yes or No from the dropdown list. If "No" Choose from the dropdown list in the "Choose from List" box.

Screening Panel Pre-litigation Outcome:

- Panel Decision Date: Date the screening panel arrived at their decision.
- Outcome of Pre-litigation Screening Panel - Please fill in the number of panel members who voted yes and the number of panel members who voted no on the three findings listed.
- Case Dismissed by Panel Chair: If the case was dismissed by the panel chair for whatever reason as outlined in Title 24 M.R.S.A § 2853, please choose yes or no from the dropdown list.
- Reason for Disposition: Choose from dropdown list. If choosing "Other" use the comment section to explain the reason.

Date of Settlement, Judgment, Award, or Closing of File: If there is a date of settlement, judgment, or award, please use this date. If not, then please use the date the file closed.

Amount of Award/settlement: If none, mark $0.00. This refers only to the award, judgment or settlement against the named insured in Report of Claim.

Allocated Claims Expense, if Any: If none, mark $0.00.

Notes to Remember:

- Please fill out the insurance company information each time you complete the form, giving the insurance company name and address, name of contact person and his/her Email address, telephone number, telephone extension number, and fax number.

- A copy of this form must be retained in the insurance company's files and be readily retrievable at the Superintendent's request.

- All insurers providing professional liability insurance to a person licensed by the Board of Licensure in Medicine or the Board of Osteopathic Licensure or to any health care provider are required to make report of claims made under the insurance with the Superintendent of Insurance pursuant to Title 24 M.R.S.A. §2601 et. seq. Insurers and their agents or employees are immune from liability for any cause of action that may be asserted against them as a result of filing the required reports. The Superintendent maintains as confidential all data derived from these reports that permits identification of insured or any incident giving rise to a claim.

Email Completed Form To:
Research and Statistics Division
Barbra.L.Garboski@maine.gov