

**AAHP-RRG UNDERWRITING FORM - CLAIM SUPPLEMENT**

Provider Name:

If you answered YES to question 7 and/or 8 under the Underwriting Information section of the AAHP-RRG Coverage Questionnaire, please complete a Claim Supplement for each claim, suit, and judgment against you.

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Patient (or Plaintiff) Name:

Date of Incident:

Date you became aware of this potential or actual malpractice claim?

How did you become aware of this claim?

Where did the event occur (facility, city and state)?

Provide a summary of the allegations or potential allegations, the alleged or potentially alleged injuries/damages, and your involvement in the care of the patient.

If the claim has been resolved, provide the date the case was settled and the amount of the settlement that was attributed to the care you provided.

If the claim has not been resolved, provide current status.

Defense Attorney (name/address):

Insurer (name/address):

**Attach an additional sheet if you need more space or wish to provide additional information.**