All State MALPRACTICE

Incident Report Form

Email the completed form to: info@allstatemalpractice.com

FORM INSTRUCTIONS: All questions must be answered. If a question does not apply, enter N/A. To submit additional information, please attach to this form.

1) Policy Number (please submit all active policy numbers) or Policy ID: _____

2) Name of Insured (as it appears on the declaration page): _____

3) DBA ("Doing Business As" - other name used): _____

4) Contact Name: _____

5) Home Phone: _____

6) Work/Business Phone: _____ Other Phone Number: _____

7) Email Address: _____

8) Current Policy Effective Date: _____

9) Current Policy Expiration Date: _____

10) State in which Incident occurred: _____

11) Date of Incident in Question*: _____

**Please be as accurate as possible with date of incident.*

- *Please be advised that in order for coverage to apply, report or discovery of the claim must occur during the policy period.*
- *If you were not insured with All State Malpractice/ Partners at the time the claim was made against you or discovered, please contact the insurance carrier with whom you were insured at that time.*

12) Please print/type here a brief description of Incident or Claim
(Please attach additional sheets as needed.)

PLEASE READ AGREEMENT AND CHECK ONE ANSWER:

The insured declares the information contained in the incident report is true, and no material facts have been suppressed or misstated.

I Agree ☐ I Do Not Agree ☐

Signature: _____ Today's Date: _____