



INCIDENT REPORTING FORM OF PROFESSIONAL INDEMNITY POLICY FOR DOCTORS & MEDICAL PRACTITIONERS

(The issue of this form is not to be taken as an Admission of Liability)

The completion and return of this form to the Company should not be delayed if any of the particulars required cannot be immediately given, they may be forwarded to the Company afterwards as soon as possible.

DETAILS OF INSURED

	Name	
	Policy No.	
	Classification of Medical Practitioner (Physician, Pathologist etc)	
	Address	
	Contact No	
	Email id	

DETAILS OF CLAIMANT

	Name of the Claimant	
	Address	
	Contact No.	
	Mention the type of professional service provided to the Claimant in detail Nature of Disease/illness diagnosed Details of treatment given to claimant	
	When was the service provided to Claimant	
	Please specify the capacity in which the claimant is making/can make the claim against you	
	When and how did you first come to know of the error/omission	
	Brief description of the incident which can lead to claim	
	Give particulars of any other insurance, if any in respect of the same risk.	

ICICI Lombard General Insurance Company Limited

IRDA Reg. No. 115

Mailing Address:

601 / 602, 6th Floor, Interface Building No. 16,
New Link Road, Malad (West),
Mumbai - 400 064.

CIN : L67200MH2000PLC129408

Registered Office Address:

ICICI Lombard House, 414, Veer Savarkar Marg,
Near Siddhivinayak Temple, Prabhadevi,
Mumbai 400 025.

INCIDENT REPORTING FORM OF PROFESSIONAL INDEMNITY
POLICY FOR DOCTORS & MEDICAL PRACTITIONERS

Toll free no : 1800 2666

Alternate no : 8655222666 (Chargeable)

E-mail : customersupport@icicilombard.com

Website : www.icicilombard.com

UIN: IRDAN115RP0008V01200203 (Retail)

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CIN : L67200MH2000PLC129408

I/We hereby agree, affirm and declare that:

- (a) The statements/information given/stated by me/us in this incident reporting form are true, correct and complete.
- (b) No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
- (c) If I/we have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I/We shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.
- (d) The receipt of this incident reporting form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.

Date: / / Place:

Signature of Insured:

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CLAIM APPLICATION FORM FOR PROFESSIONAL INDEMNITY FOR DOCTORS & MEDICAL PRACTITIONERS

(The issue of this form is not to be taken as an admission of liability)

This will be in continuation of the Incident Reporting Form dated / /

This form is only for the purpose of intimating the Company about the claims made. Insured shall not enter into compromise/settlement without the written permission of the Company. The completion and return of this form to the Company should not be delayed if any of the particulars required cannot be immediately given. They may be forwarded to the Company afterwards as soon as possible.

DETAILS OF INSURED

	Name	
	Address	
	Contact No	
	Email id	
	Policy No.	

DETAILS OF ALLEGED CLAIM

	Alleged Date & Time of Error/Omission/negligence	
	Name of the person who has been alleged for Error/Omission	
	Designation	
	Qualification	
	Brief description of the event	

DETAILS OF CLAIMANT

	Give name/es, address/es occupation/s of Claimant (Attach separate sheet, if space not sufficient)	
	Details of Injury/death/damage/loss to the claimant (Attach separate sheet, if space not sufficient)	
	Number of victims	
	Mention the capacity under which the claim is being made by the claimant (Attach the written complaint/notice given by the claimant)	
	Mention the amount of compensation claimed	

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COMPROMISE DETAILS

	Do you agree that you are liable for the incident. Give reasons	
	Reasons for compromise / settlement Please provide comprehensive detail of all reasons, game-plans/strategy for the same.	
	What is the present status of compromise/ settlement negotiations?	
	What is the quantum of liability, you are proposing to agree to?	

COURT PROCEDURE

	Has any case been filed in any court of law/tribunal against you, in relation to the incident ?	
	Have any notices / summons of the court been received by you? If yes, please provide copies of the same.	
	Details of the main Parties of the legal Proceedings	
	Has the court passed any interim or final order? If yes, please provide copies of the same	
	Also provide copies of all the documents that have been submitted to the Court either by you or the Claimants.	

DETAILS OF LEGAL ADVICE

	The Insured's proposed response to the alleged claim/complaint?	
	Does the insured propose to/has already availed of, any legal advice. If Yes, details of the lawyer/law firm together with their opinion If No, the proposed steps by the Insured to evaluate the legal liability risk in the context of its response/proposed response and the facts having bearing on the matter.	
	Estimated Legal/Defence Cost/fees which will be incurred	

MISCELLANEOUS

	Any other evidence in support of claim.	
	Give particulars of any other insurance, in respect of the same risk.	

I/We hereby agree, affirm and declare that:

- (a) The statements/information given/stated by me/us in this incident reporting form are true, correct and complete.
- (b) No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
- (c) If I/we have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I/We shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.
- (d) The receipt of this incident reporting form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.

Date: / / Place:

Signature of Insured:

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CLAIM SETTLEMENT FORM FOR DOCTORS & MEDICAL PRACTITIONERS PROFESSIONAL INDEMNITY

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1. What is the quantum of the settlement that has been arrived at between you and the Claimants?
Please provide proof of the following (agreement, understanding, court order, court award etc)
2. If decided by a court, what is the quantum of liability imposed on you?
Please provide copy of the court award.
3. What are the total defence costs that have been incurred by you, till date, if any?

DECLARATION

I/We hereby agree, affirm and declare that:

- (a) The statements/information given/stated by me/us in this incident reporting form are true, correct and complete.
- (b) No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
- (c) If I/we have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I/We shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.
- (d) The receipt of this form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.
- (e) I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.

Date: / /

Place:

Signature of Insured:

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