SECTION 11 SUPPLEMENTAL: MALPRACTICE CLAIMS HISTORY
CONFIDENTIALITY AGREEMENT, AUTHORIZATION, AND RELEASE FORM
FOR DETAILED CLAIM HISTORY

Instructions: Applicant (Insured) must complete a separate form for their current and all previous professional liability insurance carriers of the past 10 years. The forms must then be mailed by the applicant to the insurance companies.

INSURED or POLICYHOLDER: _____

POLICY # _____ SSN OR TAX ID #: _____

INSURED'S CURRENT ADDRESS: _____

_____

_____

_____ (name of insurance company, hereafter "Company") is or was the carrier of my medical professional liability insurance, and as such, maintains certain information regarding my medical practice and, specifically, the history of any malpractice claims against me. I understand that this information is extremely sensitive and confidential and may be protected by attorney-client privilege.

I am requesting that a "loss run report" from the Company be provided concerning my claims history. The report needs to identify all claims that I had with the Company, to include, but not limited to the allegation of the claim, disposition of the claim and the value of any insurance payments with respect to the claim. I authorize Company to release this information relating to claims and suits against me which is on record with Company. I understand that the information to be provided is highly confidential and should not be disclosed in any manner that would cause such information to benefit any claimant.

As a result, I and my representatives agree to maintain this information as confidential. The information will only be disclosed in the course of procuring insurance coverage from the University of Toledo's insurance program and as a part of credentialing by The University of Toledo Medical Center Medical Staff Services Office and other health care providers and insurers. Prior to any such disclosure, I will cause any such entities to agree not to disclose the information to any party. If requested or required to disclose the information in a legal proceeding, I and my representatives will immediately notify the Company in writing so that the Company may determine the appropriateness of contesting such disclosure.

I understand that neither the Company nor its authorities makes any representation or warranty as to the accuracy or completeness of the information and agree that they shall have no liability with respect to the information or its use.

I agree that money damages alone will not be sufficient remedy for any breach of the confidentiality of this information other than as stated herein either by me or my representatives, and, in addition to all other remedies, Company shall be entitled to specific performance and injunctive or other equitable relief.

_____ _____

SIGNATURE of Insured DATE

Please check one:

☐ UTP Applicant/Employee: FAX REPORT TO: 419-383-2012, ATTN: University of Toledo Physicians, Risk Manager.

☐ UT Applicant/Employee: FAX REPORT TO: 419-383-3896, ATTN: The University of Toledo Medical Center, Risk Manager.

Print Form