7701 France Avenue South, Suite 500
Minneapolis, MN 55435–5288
800–328–5532 • Fax 952–838–6808
MMICGroup.com

Prior Claim/Suit Information Addendum

This addendum is to be completed for each claim/suit made against you in the past ten years. Additional documentation may be required by MMIC upon receipt of this information.

Name of Applicant:	MMIC Policy Number (if applicable):

Claim/Suit Information

Claimant Full Name: | Age: | Gender: ☐ Male ☐ Female

Date(s) of treatment and/or surgery, which led to the allegations against you:

Nature of the allegations in the claim or suit:

Was suit ever filed? ☐ Yes ☐ No | If yes, when was it filed?

Name of other doctor(s) and hospital(s), if any, involved in claim/suit:

Disposition or current status of claim or suit: ☐ Open ☐ Closed

If open, indicate case value established by carrier: | If closed, was payment made? ☐ Yes ☐ No

If claim is not closed, was claim or suit withdrawn? ☐ Yes ☐ No

If payment was made, indicate total amount of settlement or award:

How much was paid on your behalf:

Name of insurance carrier defending you:

Provide a complete narrative description of the **medical** facts. Please include the type of treatment and/or surgery and your involvement. **Please give as complete a narrative description as possible.**

Claim/Suit Information

Claimant Full Name: | Age: | Gender: ☐ Male ☐ Female

Date(s) of treatment and/or surgery, which led to the allegations against you:

Nature of the allegations in the claim or suit:

Was suit ever filed? ☐ Yes ☐ No | If yes, when was it filed?

Name of other doctor(s) and hospital(s), if any, involved in claim/suit:

Disposition or current status of claim or suit: ☐ Open ☐ Closed

If open, indicate case value established by carrier: | If closed, was payment made? ☐ Yes ☐ No

If claim is not closed, was claim or suit withdrawn? ☐ Yes ☐ No

If payment was made, indicate total amount of settlement or award:

How much was paid on your behalf:

Name of insurance carrier defending you:

Provide a complete narrative description of the **medical** facts. Please include the type of treatment and/or surgery and your involvement. **Please give as complete a narrative description as possible.**

Claim/Suit Information

Claimant Full Name: | Age: | Gender: ☐ Male ☐ Female

Date(s) of treatment and/or surgery, which led to the allegations against you:

Nature of the allegations in the claim or suit:

Was suit ever filed? ☐ Yes ☐ No | If yes, when was it filed?

Name of other doctor(s) and hospital(s), if any, involved in claim/suit:

Disposition or current status of claim or suit: ☐ Open ☐ Closed

If open, indicate case value established by carrier: | If closed, was payment made? ☐ Yes ☐ No

If claim is not closed, was claim or suit withdrawn? ☐ Yes ☐ No

If payment was made, indicate total amount of settlement or award:

How much was paid on your behalf:

Name of insurance carrier defending you:

Provide a complete narrative description of the **medical** facts. Please include the type of treatment and/or surgery and your involvement. **Please give as complete a narrative description as possible.**