



Underwritten by a Curi company:

MMIC Insurance, Inc. | UMIA Insurance, Inc.
Arkansas Mutual Insurance Company
MMIC Risk Retention Group, Inc.

Prior Claim / Suit Questionnaire

curi.com

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

Name of Applicant:	Curi Policy Number (if applicable):
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Claim/Suit Information

Claimant Full Name:	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when was it filed?
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If claim is not closed, was claim or suit withdrawn?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 InformationClaimant 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 ClosedIf open, indicate case value established by carrier: _____ If closed, was payment made? Yes NoIf claim is not closed, was claim or suit withdrawn?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 InformationClaimant 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 ClosedIf open, indicate case value established by carrier: _____ If closed, was payment made? Yes NoIf 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.**