



PODIATRIST APPLICATION

APPLICATION CHECKLIST

- Type or print clearly in ink.
- Answer all questions fully and completely. Partially completed applications cannot be processed and will be returned to you for completion.
- The application asks that you provide information regarding hospital affiliations, practice associations, etc. This information is requested to provide us with an understanding of your practice but does not mean that a policy, if issued, would cover such entities or persons.
- If you wish to explain any of your answers, please use the Remarks section on page 11. If you need more space, please attach additional pages.
- Please ensure that you sign and date the application on page 12 for California and Rhode Island applicants or page 13 for Alaska applicants.
- Please provide loss runs for the previous ten years, or since the date you began practicing medicine, whichever is more recent. The loss runs must be less than 90 days old.
- Please make a copy of the completed application and supporting documents for your records.
- If you engage in the electronic management and distribution of patients' protected health information (PHI), and such information is released to NORCAL, you are considered a *Covered Entity* under HIPAA and thus required to maintain a Business Associate Agreement with NORCAL. For your convenience, NORCAL has enclosed a Business Associate Agreement to satisfy the HIPAA requirement. You do not need to sign and/or return the Agreement; it is intended simply to be filed along with your other HIPAA compliance documents. The Agreement can also be found online at www.norcalmutual.com.

SECTION I IDENTIFYING INFORMATION

Applicant Name (Last, First Middle)		Professional Designation		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / /	
Primary Practice Address	City	County	State	Zip Code	Telephone # () -	Fax # () -
Home Address	City		State	Zip Code	Telephone # () -	Fax # () -
Email Address						

SECTION II COVERAGE INFORMATION

1. Please identify the name of the physician or group under whose professional liability insurance coverage you wish to apply:

(Name of Physician/Group)

NOTE: If your application is approved, you will be added to the physician's or group's policy via endorsement. Coverage will be extended only while you are acting within the course and scope of your duties for the physician or group and will be subject to the terms, conditions and limitations of the policy.

2. Please describe your association with the physician or group identified above (e.g., employee):

3. Please identify the Requested Effective Date (the date you wish coverage to begin)

_____ 12:01 a.m. Local Time
Month Day Year

NOTE: NORCAL should receive the application at least thirty days before the Requested Effective Date.

4. If you are a California applicant, please select the type of coverage that you desire. **Note:** Alaska applicants will be provided separate limits of liability if coverage is approved, and Rhode Island applicants will share in the Named Insured's limits of liability if coverage is approved.

Separate limits of liability. If this option is chosen and you are approved for coverage, you will have your own separate limits of liability.

Shared limits of liability. If this option is chosen and you are approved for coverage, you will share in the Named Insured's limits of liability.

SECTION III PRACTICE LOCATIONS

1. Please complete the following regarding all non-hospital locations at which you will render professional health care services as of the Requested Effective Date. Please photocopy this page if additional space is needed.

Name of Location	Address	Location Type (i.e., office, surgery center, nursing home, etc.)

2. Please complete the following regarding any other non-hospital locations at which you have rendered professional health care services within the past ten years. Please photocopy this page if additional space is needed.

Name of Location	Address	Location Type (i.e., office, surgery center, nursing home, etc.)	Dates From (Mo/Yr) To (Mo/Yr)
			-
			-
			-

3. As of the Requested Effective Date, will you provide any professional health care services outside the scope of your duties for the physician or group identified in Section II? Yes No

If yes, please complete the following. Please photocopy this page if additional space is needed.

Name of Location	Address	Description of Practice and Hours Per Week	Name of Insurer

4. Please list all hospitals at which you currently maintain or will be applying for staff privileges. Please photocopy this page if additional space is needed.

Name of Facility	Location (City and State)	Type of Privileges
		<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Provisional <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Provisional <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Provisional <input type="checkbox"/> Other: _____

5. If you checked "provisional" or "other," please explain in the Remarks section on page 11.
6. If you do not have hospital privileges, please explain why you do not have them and identify the means you use to admit your patients should the need arise:

SECTION IV GENERAL PRACTICE INFORMATION

1. Please indicate the average number of hours that you will work per week on behalf of the physician or group identified in Section II. Do not count your hours more than once.

Office: _____ On-call hours actually worked: _____
 Scheduled surgery: _____ Other clinical work: _____
 Hospital rounds: _____ Other work: _____

2. Please provide the following based on the work that you will perform on behalf of the physician or group identified in Section II.

Average number of patients cared for by you per week: _____
 Average number of hospital admissions by you per week: _____
 Average number of outpatient surgical procedures performed by you per week: _____
 Average number of inpatient surgical procedures performed by you per week: _____

SECTION V LICENSES

1. Please complete the following regarding *all* states where you are or have been licensed to practice as a health care professional.

State	License Type (e.g., Podiatrist)	License Number	Current Status	If Inactive, Reason for Inactive Status
			<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	
			<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	
			<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	
			<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	
			<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	

2. Federal DEA License: Number: _____ Status: _____ Expiration Date: _____

SECTION VI EDUCATION, TRAINING AND CERTIFICATION

1. List all training programs you have entered, whether or not you graduated or completed the training.

Podiatric School:

Name of School	City, State	Dates (from – to)
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Residency:

Name of Facility	City, State	Dates (from – to)
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Type of Residency (check one):

- | | |
|--|---|
| <input type="checkbox"/> Podiatric Surgery (1 year) | <input type="checkbox"/> Podiatric Medicine and Surgery (2 years) |
| <input type="checkbox"/> Podiatric Surgery (2 years) | <input type="checkbox"/> Podiatric Medicine and Surgery (3 years) |
| <input type="checkbox"/> Primary Podiatric Medicine (1 year) | <input type="checkbox"/> Podiatric Orthopedics (1 year) |
| <input type="checkbox"/> Rotating Podiatric (1 year) | <input type="checkbox"/> Other (specify): _____ |

Fellowship:

Type _____

Name of Facility	City, State	Dates (from – to)
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Other Training:

Type _____

Name of Location	City, State	Dates (from – to)
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2. Did you successfully complete each training program that you started? **Yes** **No**

If **no**, please explain in the Remarks section on page 11.

3. Please explain any gaps in your training, if applicable, in the Remarks section on page 11.

4. Are you *currently* board certified or board qualified by the American Board of Podiatric Orthopedics and Primary Podiatric Medicine or the American Board of Podiatric Surgery? **Yes** **No**

Note: Board qualified refers to one who has passed the written examination but not the oral examination.

If **yes**, please submit proof of your certification/qualification and identify which of the following apply:

American Board of Podiatric Orthopedics and Primary Podiatric Medicine: Certified Qualified

American Board of Podiatric Surgery in foot surgery: Certified Qualified

American Board of Podiatric Surgery in reconstructive rearfoot/ankle surgery: Certified Qualified

If you are not board certified or board qualified, are you scheduled to take the examination within the next year? **Yes** **No**

SECTION VII PROCEDURES AND SERVICES

Procedures

1. Please complete the following regarding the procedures that you will perform:

Procedure	Estimated Number To Be Performed Annually	Procedure	Estimated Number To Be Performed Annually
<input type="checkbox"/> Assisting in Surgery		<input type="checkbox"/> Incision and drainage	
<input type="checkbox"/> Biopsy		<input type="checkbox"/> Joint injection	
<input type="checkbox"/> Debridement		<input type="checkbox"/> Nail removal (avulsion)	
<input type="checkbox"/> Dislocation repair – closed treatment		<input type="checkbox"/> Nail trimming	
<input type="checkbox"/> Extracorporeal shock wave therapy		<input type="checkbox"/> Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus)	
<input type="checkbox"/> Foreign body removal		<input type="checkbox"/> Trigger point injection	
<input type="checkbox"/> Fracture reduction – closed reduction of simple fractures		<input type="checkbox"/> Wart (verrucae) removal	
<input type="checkbox"/> <i>Soft tissue surgery</i> *: soft tissue lesions in the subcutaneous or deep structures of the foot and ankle. This includes endoscopic plantar fasciotomy procedures, but excludes nails, excision of verruca and minor skin lesions.			
<input type="checkbox"/> <i>Digital surgery</i> *: osseous procedures of the phalanges			
<input type="checkbox"/> <i>Lesser metatarsal surgery</i> *: osseous procedures of the metatarsals, metatarsophalangeal joints and metatarsocuneiform joints			
<input type="checkbox"/> <i>First metatarsal surgery</i> *: osseous procedures of the first metatarsal and first metatarsophalangeal joint, and first metatarsal cuneiforms			
<input type="checkbox"/> <i>Rearfoot-ankle surgery</i> *: surgery on osseous, articular, neurovascular and musculotendinous structures proximal to Lisfranc's joint			

* The definitions for these categories are based on the Council on Podiatric Medical Education's *Standards, Requirements and Guidelines for Approval of Residencies in Podiatric Medicine*.

2. If you indicated that you perform extracorporeal shock wave therapy and/or paring or cutting of benign hyperkeratotic lesions and the residency you completed was the primary podiatric medicine or the podiatric orthopedics residency, please submit proof of the training that you received for these procedures.

3. Please identify any other procedures you perform that are not identified above or that are not within one of the above categories:

4. Do you perform amputations? Yes No

If yes, do you perform them further proximal than the Chopart's joint? Yes No

5. Do you perform procedures on any of the following? Yes No

If yes, please check all that apply and explain in the space provided below:

- Tibia and/or fibula including the ankle Tibia and/or fibula above the ankle
 Achilles tendon Extensor tendon Peroneal tendon Posterior tibial tendon
-

6. Do you perform any of the following procedures? Yes No

If yes, please check all that apply and explain in the space provided below:

- Acupuncture Cosmetic Procedures Prolotherapy
-

7. Do you perform any procedures or provide any services not considered usual and customary to podiatric medicine? Yes No

If yes, please explain:

Anesthesia

1. Do you perform any procedure in which the patient has been administered spinal/epidural anesthesia, moderate/conscious sedation, deep sedation or general anesthesia? Yes No

If yes, please complete the following:

Type of Anesthesia	Locations	Anesthesia Provider
<input type="checkbox"/> Spinal/Epidural	<input type="checkbox"/> Hospital <input type="checkbox"/> Accredited Surgery Center* <input type="checkbox"/> Unaccredited Surgery Center* <input type="checkbox"/> Other: _____	<input type="checkbox"/> Anesthesiologist <input type="checkbox"/> CRNA <input type="checkbox"/> You <input type="checkbox"/> Other: _____
<input type="checkbox"/> Conscious/Moderate Sedation	<input type="checkbox"/> Hospital <input type="checkbox"/> Accredited Surgery Center* <input type="checkbox"/> Unaccredited Surgery Center* <input type="checkbox"/> Other: _____	<input type="checkbox"/> Anesthesiologist <input type="checkbox"/> CRNA <input type="checkbox"/> You <input type="checkbox"/> Other: _____
<input type="checkbox"/> Deep Sedation	<input type="checkbox"/> Hospital <input type="checkbox"/> Accredited Surgery Center* <input type="checkbox"/> Unaccredited Surgery Center* <input type="checkbox"/> Other: _____	<input type="checkbox"/> Anesthesiologist <input type="checkbox"/> CRNA <input type="checkbox"/> You <input type="checkbox"/> Other: _____
<input type="checkbox"/> General Anesthesia	<input type="checkbox"/> Hospital <input type="checkbox"/> Accredited Surgery Center* <input type="checkbox"/> Unaccredited Surgery Center* <input type="checkbox"/> Other: _____	<input type="checkbox"/> Anesthesiologist <input type="checkbox"/> CRNA <input type="checkbox"/> You <input type="checkbox"/> Other: _____

* Accredited refers to a facility accredited by the AAAASF, AAAHC or IMQ, or certified as a surgery center by Medicare

2. If you indicated for question 1 that someone other than an anesthesiologist or CRNA provides one of the indicated types of anesthesia, please complete the following:

a. Do you maintain hospital privileges for each type of anesthesia identified? Yes No

If no, please explain:

b. Please identify for what procedures someone other than an anesthesiologist or CRNA administers the anesthesia and identify the designation and qualifications of the individual(s) who monitors the patients:

Drugs, Devices and Clinical Studies

1. Do you use, administer, distribute or prescribe any drugs, pharmaceuticals, devices or equipment disapproved or not yet approved by the United States Food and Drug Administration (FDA) for treatment of human beings? Yes No

If yes:

a. Please describe: _____

b. If the applicable use(s) is/are part of a clinical study, please provide the following information for each clinical study:

- i. A copy of the clinical study's protocol
- ii. Proof of its FDA or IRB approval, if not stamped on the protocol
- iii. A copy of the consent form, if it is not FDA or IRB approved

2. Do you use, administer, distribute or prescribe any FDA-approved drugs, pharmaceuticals, devices or equipment in a manner not approved by the FDA (i.e., off-label use)? Yes No

If yes, are all of your off-label uses supported by appropriate precedent for effectiveness and safety (i.e., within the standard of care)? Yes No

If no:

a. Identify each drug, pharmaceutical, device and/or equipment, its FDA-approved use and your off-label use:

b. Provide a copy of the informed consent form that you use for each such off-label use.

Telemedicine, Email and Advertising

Telemedicine is defined as “the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video or data communications. Neither a telephone conversation nor an electronic mail message between a licensed health care practitioner and another licensed health care practitioner and/or between a licensed health care practitioner and a patient constitute telemedicine.”

1. Do you provide telemedicine services? **Yes** **No**

If yes, please explain in the Remarks section on page 11.

2. Do you communicate online/via email with patients and/or potential patients?

If yes, complete 2a - c.

- a. Please check all that apply to your practice:

- Provide a diagnosis to, treatment for, prescription for or transfer of medical data to any person(s) via the Internet or other electronic mail system, videoconference, telephone or other information systems for whom you have performed a good faith prior in-office examination?
- Provide a diagnosis to, treatment for, prescription for or transfer of medical data to any person(s) via the Internet or other electronic mail system, videoconference, telephone, or other information systems for whom you did **not** perform a good faith prior in-office examination?

- b. If you communicate online/via email with patients and/or potential patients with whom you did not perform a good faith prior in-office examination, please explain in the Remarks section on page 11.

- c. Do any of the patients with whom you communicate online/via email reside in a state other than the one in which your primary office is located? **Yes** **No**

If yes, please explain and identify each state in the Remarks section on page 11.

3. Do you advertise your practice in any way other than listing your name, address and telephone number in the telephone book? **Yes** **No**

If yes, please submit copies of all of your advertisements (excluding those that appear on your website, if applicable) and/or the script of any voice, film or TV media.

4. Is there a website related to your practice? **Yes** **No**

If yes, what is the website address(es): _____

Miscellaneous

1. Do you interpret your own images (i.e., x-rays, CT-scans, etc.)? **Yes** **No**

If yes, does a radiologist over-read the images that you interpret? **Yes** **No**

If a radiologist does not over-read the images, do you render a formal written report for those images not over-read by a radiologist? **Yes** **No**

If no, please explain:

2. Do you have any medical director, management or similar responsibilities? **Yes** **No**

If yes, please explain:

SECTION VIII SUPPLEMENTAL QUESTIONS

If you answer YES to any one of the following questions, you must provide a detailed written narrative (including, but not limited to, date of occurrence, reason for occurrence and resolution) and pertinent documentation (e.g., nonrenewal or declination notice, medical board documents, letters from hospital, diversion program, treating physician, etc.).

1. Has any professional liability insurance company **ever** canceled, nonrenewed or modified (e.g., involuntarily reduced limits, restricted coverage, added a deductible and/or surcharge, etc.) your insurance, declined to offer you coverage or notified you of its intent to pursue such action? Yes No
2. Has your license to practice as a health care professional in any jurisdiction, your DEA registration, or any applicable controlled substance license or registration in any jurisdiction **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, fined, subject to probationary terms or conditions or otherwise investigated or limited in any way? Yes No
3. Has any governmental agency **ever** investigated you, placed you on probation, suspended you or taken any action against you? Yes No
4. Have your clinical privileges, memberships, contractual participation in or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, subject to probationary terms or conditions or otherwise investigated or limited in any way for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? Yes No
5. Have you **ever** surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges with; terminated contractual participation or employment in; or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence, improper professional conduct or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? Yes No
6. Have you **ever** been convicted of or admitted to committing a misdemeanor, including a DUI, but excluding minor traffic violations? Yes No
7. Have you **ever** been charged with, been convicted of or admitted to committing a felony? Yes No
8. Have you **ever** been accused of sexual misconduct? Yes No
9. Have you **ever** had any contact of a sexual nature with a patient or former patient? Yes No
10. Have you **ever** had a problem with, been evaluated for, been diagnosed with, been treated for or are currently being treated for alcohol, narcotic or any other substance addiction, sexual addiction or mental illness? Yes No
11. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice podiatry? Yes No

FOR CALIFORNIA AND RHODE ISLAND APPLICANTS ONLY

Warranties and Authorization to Release Information

I understand that this application and any supplemental information supplied by me or on my behalf is incorporated into and made a part of any policy of insurance that may be issued to the physician or group by NORCAL ("the Company").

I understand it is my responsibility to obtain and review a copy of the insurance policy. I also understand I may ask any questions about any policy language that is not clear to me.

I represent and warrant the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the Company in considering this application for insurance.

I understand that if a dispute arises between me and NORCAL, the dispute will be submitted to binding arbitration.

I understand that the physician's or group's policy (including my coverage), if issued, can be canceled for failure to pay the premium by the due date stated on the invoice.

I understand that, in the event my coverage is canceled, any unearned premiums will be refunded to the person or group that paid NORCAL (i.e., the payor).

I understand that I (or the physician's or group's Authorized Representative) must notify NORCAL immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on my behalf, including changes in my partners or associates, medical license, professional office premises, medical procedures or administrative responsibilities, or hospital privileges.

I understand that NORCAL generally does not cover any liability of another person or organization that I assume under an oral or written contract or agreement.

I understand that NORCAL generally does not cover any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by me or others trading under my name.

I understand that if my application is approved and I am added to the physician's or group's policy, coverage would be extended only while I am acting within the course and scope of my duties for the physician or group, subject to the terms, conditions and limitations of the policy.

I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and my past and present medical group(s), association(s), society(ies) and their insurance agents, brokers or consultants; any hospital or other health care facility or organization where I presently hold, am applying for or previously held staff privileges or panel membership; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals NORCAL deems necessary. I understand NORCAL, at its discretion, may obtain background information to aid in its evaluation of my insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release NORCAL, its agents and representatives, from any liability arising from any exchange of information about me.

Signature

Date

Name (Print)

FOR ALASKA APPLICANTS ONLY

Representations and Authorization to Release Information

I understand that this application and any supplemental information supplied by me or on my behalf is incorporated into and made a part of any policy of insurance that may be issued to the physician or group by NORCAL (“the Company”).

I understand it is my responsibility to obtain and review a copy of the insurance policy. I also understand I may ask any questions about any policy language that is not clear to me.

I represent the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the Company in considering this application for insurance.

I understand that if a dispute arises between me and NORCAL, the dispute will be submitted to binding arbitration.

I understand that the physician’s or group’s policy (including my coverage), if issued, can be canceled for failure to pay the premium by the due date stated on the invoice.

I understand that, in the event my coverage is canceled, any unearned premiums will be refunded to the person or group that paid NORCAL (i.e., the payor).

I understand that I (or the physician’s or group’s Authorized Representative) must notify NORCAL immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on my behalf, including changes in my partners or associates, medical license, professional office premises, medical procedures or administrative responsibilities, or hospital privileges.

I understand that NORCAL generally does not cover any liability of another person or organization that I assume under an oral or written contract or agreement.

I understand that NORCAL generally does not cover any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by me or others trading under my name.

I understand that if my application is approved and I am added to the physician’s or group’s policy, coverage would be extended only while I am acting within the course and scope of my duties for the physician or group, subject to the terms, conditions and limitations of the policy.

I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and my past and present medical group(s), association(s), society(ies) and their insurance agents, brokers or consultants; any hospital or other health care facility or organization where I presently hold, am applying for or previously held staff privileges or panel membership; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals NORCAL deems necessary. I understand NORCAL, at its discretion, may obtain background information to aid in its evaluation of my insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release NORCAL, its agents and representatives, from any liability arising from any exchange of information about me.

Signature

Date

Name (Print)

CLAIM INFORMATION FORM

Name of Patient: _____ Gender: Male Female

Age of Patient (at time of treatment): _____

Name of Claimant (if different than patient): _____

Your Relationship to Patient (e.g., attending podiatrist, primary surgeon, assistant surgeon, consultant): _____

Allegation: _____

Location of Incident: _____

Additional Defendants: _____

Date Incident or Claim Was Reported to the Insurance Company: _____

Name of Insurance Company: _____

Disposition or Current Status of the Incident, Claim or Suit

Open

Incident has been reported but claim or suit has not been filed

Claim or suit has been filed and is awaiting start of arbitration, mediation, trial, etc.

Claim or suit is currently in arbitration or mediation or is being tried in court

Settlement has been made or judgment returned but remains open

Closed Date Closed (month/day/year): _____

Incident was reported but claim or suit was not filed

Claim or suit was filed but was dismissed or dropped before trial

Claim or suit was filed but settlement was made

Verdict or judgment was made in your favor

Verdict or judgment was made in favor of the plaintiff

Total loss payment amount (if payment made): _____

Amount paid on your behalf (if different): _____

Total verdict amount (if different than total loss payment amount): _____

