Initial Incident Report

Print this form and overnight mail, email or fax it to:
CPH & Associates, 711 S. Dearborn, Suite 205, Chicago, IL 60605
Fax: 312-987-0902—call 800-875-1911 5 minutes after faxing to confirm receipt.
Email: Claims@cphins.com

You must answer ALL questions on this form. If something does not apply to you, write "N/A" on that line. Attach additional information as necessary.

1) Policy Number:

(If you have held more than one policy through CPH and Associates, please make sure to give all policy numbers and include the corresponding dates for each on questions 6 & 7)

2) Name of Insured:

(As it appears on your declarations page)

3) DBA:

("Doing Business As"—other name used, if applicable)

4) Home Phone:

5) Work Phone: **Email:**

6) Date First Insured with CPH and Associates:

7) Expiration Date of Current Policy:

8) Location of Incident (State):

9) Prior Carrier(s):

(Include names of your prior Professional Liability insurance carriers and effective dates of coverage with each).

10) Have any specific procedures or elements of practice been excluded from coverage under any of your prior carriers?

☐ **Yes**† ☐ **No**

†*If yes, include the name of the carrier and the specific procedure or element of practice excluded.*

11) Have any of your prior carriers defended any claims or paid any settlements or judgments on your behalf?

☐ **Yes**† ☐ **No**

†*If yes, include the name of the carrier and amounts paid, and provide details of the particular claim, suit, or complaint.*

12) Do you currently have any other pending professional liability claims, suits, or board investigations *other than the information being reported on this Initial Incident Report*? ☐ **Yes**†† ☐ **No**

††*If yes, please provide a full explanation of the matter including the name of the court or board with which the suit or complaint was filed, the caption and docket number of the case (if any), the outcome or current status of the case, and any other relevant details.*

13) Date of Incident in Question*:

14) Dates of Treatment/Evaluation of Involved Client(s)*:

***Be as accurate as possible with dates of incident/treatment.**

- ***Please be advised that in order for coverage to apply, dates of treatment or incident resulting in any claim must fall within the policy period*.**
- ***If you were not insured with CPH and Associates at the time of the incident or treatment, please contact your other insurance carrier.***
- ***If treatment of the client(s) in question overlaps more than one insurance policy, you should notify all involved insurance carriers about the potential or pending claim.***

15) Type of Claim (*check all that apply*):

☐ **Professional Liability**

☐ **Bodily Injury, Property Damage, Personal Injury, Advertising Injury, or Host Liquor Liability. ***If you check this box, you must complete page 3 of this form.****

☐ **Deposition Expense**

☐ **State Licensing Board Investigation Expense**

☐ **Medical Expense**

☐ **First Aid Coverage**

☐ **Assault Coverage**

16) Did you receive any of the following written documentation? (*check all that apply*):

☐ **Summons / Letter of intent** ☐ **Subpoena for deposition**
☐ **Notice of complaint** ☐ **Other (describe):** _____

If so, what date was it delivered? ____/___/_____
mm / dd / yyyy

******Please forward documentation received directly from a court, attorney, complainant, and/or regulatory agency. Treatment notes and other patient Private Health Information are not necessary at this time.***

17) Do you suspect that a claim or suit may arise out of the incident or treatment in question? ☐ **Yes** ☐ **No**

18) Brief Description of Incident or Claim, and reasons why you suspect a claim or suit may arise:
(Please print legibly or type; attach additional sheets as needed.)

PLEASE READ AGREEMENT AND CHECK ONE ANSWER:

The insured declares the information contained in the incident report is true and that no material facts have been suppressed or misstated.

☐ **I Agree** ☐ **I Do Not Agree**

Signature: _____ **Today's Date:** _____

PLEASE ATTACH ALL SUPPORTING DOCUMENTATION, SUCH AS COURT DOCUMENTS AND RELATED CORRESPONDENCE (FROM A LICENSING BOARD AND ITS AGENTS OR INVESTIGATORS, THE COMPLAINANT'S ATTORNEY, OR OTHER RELEVANT PARTIES).

PAGE 3: SUPPLEMENTAL FORM FOR BODILY INJURY, PROPERTY DAMAGE, PERSONAL INJURY, ADVERTISING INJURY, PERSONAL LIABILITY, OR HOST LIQUOR LIABILITY INCIDENTS.

19) Location of incident: _____
(street, suite #, city, state, zip code)

20) Do you rent or own this location? ☐ **Rent** ☐ **Own**

21) If you own this location, what percentage of the building is owned by you? ☐ **100%** ☐ **Other:** _____

List all names of co-owners: _____

22) If this is a bodily injury or property damage incident, where on the premises did the injury take place?

_____

23) If this is a bodily injury or property damage incident occurring OFF-PREMISES, where did the injury take place? Did this injury involve a vehicle?

24) List all services you provide at this location:

25) Name of therapist(s) involved in incident:

26) Name of therapist(s) involved in treatment of injured client:

27) Describe your relationship to the injured party:

28) If a bodily injury or property damage incident, who witnessed the incident?

29) Prior Commercial General Liability Carrier(s):

(Include names of your prior General Liability insurance carriers and effective dates of coverage with each).

PLEASE READ AGREEMENT AND CHECK ONE ANSWER:

The insured declares the information contained in the incident report is true and that no material facts have been suppressed or misstated.

☐ **I Agree** ☐ **I Do Not Agree**

Signature: **Today's Date:**