**Section 928.EXHIBIT B Illinois Medical Professional Liability Insurance Uniform Claims Report – Reporting Instructions**

As required by Section 155.19 of the Insurance Code [215 ILCS 5/155.19] and 50 Ill. Adm. Code 928:

1. File all opened, closed, re-opened, and re-closed medical professional liability insurance claims and lawsuits, including any updates, with the DOI on a quarterly basis. For closed claims, include claims closed without payment. Insurance claim means a formal or written demand for compensation under a medical professional liability insurance policy relating to allegations of liability on the part of one or more providers for any act, error or omission in the rendering of, or failure to render, medical services for medically related injuries. Insurance claim includes any instance for which benefits or compensation are payable or eligible to be paid under any coverage under the policy. Lawsuit means a complaint filed in any court in this State alleging liability on the part of one or more providers for any act, error or omission in the rendering of, or failure to render, medical services for medically related injuries.

2. File separate reports for each defendant you insure. Each filing of a claim or lawsuit report shall be identified with a unique claim number. If more than one defendant/insured is associated with an incident, a unique claim number is required for each defendant/insured. If more than one claimant/injured party is associated with an incident, a unique claim number is required for each claimant/injured party. When there are multiple associated claims/lawsuits, report the incident identifier in the other claims information section.

3. RESPONSES TO ALL FIELDS ARE REQUIRED. For open claim reports, complete Insurer Information through Contact Person Information. When updating reports, any information may be updated. For closed claim reports, all fields are required.

---------------------------------------------------------------------------------------------------------------------

**Insurer Information**

1a. Insurer Name (not group name) (Maximum = 40 characters).

1b. Insurer 9-digit FEIN. Entities without a Federal Employer Identification Number (FEIN), contact the DOI for assigned number.

**Initial Claim Information**

2a. Claim ID. For each open claim report, assign a distinguishing claim number sufficient to enable the Department of Insurance (DOI) to track a particular claim over a period of years. This claim number should consist of a unique sequence of letters and/or numbers. Once a claim number has been assigned, it should not be repeated for any future claim. One claim record should be reported for each named individual or entity formally alleged to have contributed to an injury or grievance and from whom a malpractice payment is being sought. On re-opened claims, use the same claim number as the original claim file that is being re-opened.

2b. Date of Principal or Alleged Injury (MM/DD/YYYY). Report the date of the earliest alleged error or omission that was the first necessary if not sufficient cause of the alleged medical injury.

2c. Date Incident First Reported to Insurer (MM/DD/YYYY). Date of alleged injury first reported to the insurer.

2d. Date Claim Opened by Insurer (MM/DD/YYYY).

2e. Date Claim Re-Opened by Insurer (MM/DD/YYYY).

2f. Date of Original Closure (MM/DD/YYYY). Only applicable if claim was re-opened.

2g. Date of Final Closure (MM/DD/YYYY). The date of final disposition or settlement of a claim. Payments for defense costs or indemnity may occur after the date of closure (as in a structured settlement).

**Insured Information**

3a. Profession or Business Code. (1) Physician or Surgeon\*; (2) Hospital; (3) Nurse\*; (4) Nursing Home; (5) Dentist\*; (6) Pharmacy; (7) Optometrist\*; (8) Chiropractor\*; (9) Podiatrist/Chiropodist\*; (10) Clinic/Corporation; (11) Other\* – Employee (Maximum = 25 characters). A code with an asterisk (\*) requires a "Type of Practice Code" as well.

3b. Type of Practice Code. (1) Institutional, including Academic; (2) Professional Corporation, Partnership, or Group; (3) Self-Employed; (4) Hospital; (5) Nursing Home; (6) All Other Employees; (7) Intern or Resident.

3c. Insured's Name, including suffix such as MD, DO, etc.

3d. Insured's Illinois License Number. Enter FEIN for clinics and corporations.

3e. Medical Specialty Codes. Select the most relevant specialty code from the following table.

|  |  |
| --- | --- |
| **Code** | **Description** |
| **Physician Specialties** | |
| 01 | Allergy and Immunology |
| 03 | Aerospace Medicine |
| 05 | Anesthesiology |
| 10 | Cardiovascular Diseases |
| 13 | Child Psychiatry |
| 20 | Dermatology |
| 23 | Diagnostic Radiology |
| 25 | Emergency Medicine |
| 29 | Forensic Pathology |
| 30 | Gastroenterology |
| 33 | General/Family Practice |
| 35 | General Preventive Medicine |
| 37 | Hospitalist |
| 39 | Internal Medicine |
| 40 | Neurology |
| 43 | Neurology, Clinical Neurophysiology |
| 45 | Nuclear Medicine |
| 50 | Obstetrics & Gynecology |
| 53 | Occupational Medicine |
| 55 | Ophthalmology |
| 59 | Otolaryngology |
| 60 | Pediatrics |
| 63 | Psychiatry |
| 65 | Public Health |
| 67 | Clinical Pharmacology |
| 69 | Physical Medicine & Rehabilitation |
| 70 | Pulmonary Diseases |
| 73 | Anatomic/Clinical Pathology |
| 75 | Radiology |
| 76 | Radiation Oncology |
| 80 | Colon & Rectal Surgery |
| 81 | General Surgery |
| 82 | Neurological Surgery |
| 83 | Orthopedic Surgery |
| 84 | Plastic Surgery |
| 85 | Thoracic Surgery |
| 86 | Urological Surgery |
| 98 | Other Specialty – not classified |
| 99 | Unspecified |

|  |  |
| --- | --- |
| **Dental Specialties** | |
| D1 | General Dentistry (no specialty) |
| D2 | Dental: Public Health |
| D3 | Endodontics |
| D4 | Oral and Maxillofacial Surgery |
| D5 | Oral and Maxillofacial Pathology, Orthodontics and Dentofacial |
| D6 | Orthopedics |
| D7 | Pediatric Dentistry |
| D8 | Periodontics |
| D9 | Prosthodontics |
| DA | Oral and Maxillofacial Radiology |
| DB | Unknown |

3f. County of Insured's Principal Place of Practice for Rating Purposes.

3g. Policy Limits Available, Primary Coverage. Policy limits available for the claim being reported under the insured's primary coverage.

3h. Policy Limits Available, Excess Coverage. Policy limits available for the claim being reported under the insured's excess coverage.

**Place of Injury Information**

4a. Place Where Alleged Injury Occurred Code. Enter only one. (1) Hospital Inpatient Facility\*; (2) Emergency Room; (3) Hospital Outpatient Facility\*; (4) Nursing Home\*; (5) Physician's Office; (6) Patient's Home; (7) Other Outpatient Facility, including Clinics\*; (U) Unknown\*; (X) Other\* – describe place (Maximum = 25 characters).

A code with an asterisk (\*) requires a "Location Within Institution Code" as well.

4b. Location Within Institution Code. (1) Patient's Room; (2) Labor/Delivery Room; (3) Operating Suite; (4) Recovery Room; (5) Critical Care Unit; (6) Special Procedure Room; (7) Nursery; (8) Radiology; (9) Physical Therapy Department; (U) Unknown; (X) Other – describe (Maximum = 25 characters).

4c. County Where Alleged Injury Occurred. Full name of the county in which the injury is alleged to have occurred.

**Injured Person Information**

5a. Injured Person's Name.

5b. Injured Person's Gender. M F

5c. Injured Person's Age. Enter age of injured person at the date of injury.

**Other Claim Information**

6a. Total Number of Defendants. Enter total number of persons or corporations that you insure that are involved in the incident relating to this claim.

6b. Incident Identifier. Each reporting entity should assign a unique numeric identifier for each incident or occurrence. An occurrence is an event or series of events leading to an allegation of malpractice, and that may involve allegations against multiple individuals and entities. An occurrence is defined causally and may or may not be constrained in time. For example, multiple failures to diagnose a given illness may occur over a period of years. Such a series of events would be considered a single occurrence. Each claim submitted for providers involved in a single occurrence should be assigned the same incident identifier.

**Contact Person Information**

7a. Name of Person Responsible for Preparing this Report.

7b. Title of Person Responsible for Preparing this Report.

7c. Contact Person Name (if different than Name of Person Responsible for Preparing this Report).

7d. Contact Person Telephone Number.

7e. Contact Person Email Address.

##### Plaintiff Attorney Information

8a. Plaintiff Attorney's Name or Name of Law Firm.

8b. Plaintiff Attorney's Office City.

8c. Plaintiff's Attorney's Office State.

**Claim Data Information**

9a. Nature and Substance of Claim. Give complete description of all actions and circumstances causing the claim, including allegations made by claimant. (Maximum = 250 characters)

9b. Allegation Codes Related to Claim. Enter as many codes as needed. Use DOI 3-digit codes listed below. (1) Diagnosis Related; (2) Anesthesia Related; (3) Surgery Related; (4) Medication Related; (5) Intravenous and Blood Products Related; (6) Obstetrics Related; (7) Treatment Related; (8) Monitoring Related; (9) Biomedical Equipment/Product Medication Related; (10) Miscellaneous Related.

DOI 3-digit Allegation Code choices:

Diagnosis-Related 010 – Failure to Diagnose (e.g., concluding that patient has no disease or condition worthy of follow-up or observation)

020 – Wrong Diagnosis or Misdiagnosis (e.g., original diagnosis is incorrect)

030 – Improper Performance of Test

040 – Unnecessary Diagnostic Test

050 – Delay in Diagnosis

060 – Failure to Obtain Consent/Lack of Informed Consent

070 – Diagnosis Related – Not Otherwise Classified

Anesthesia-Related 110 – Failure to Complete Patient Assessment

120 – Failure to Monitor

130 – Failure to Test Equipment

140 – Improper Choice of Anesthesia Agent or Equipment

150 – Improper Technique/Induction

160 – Improper Equipment Use

170 – Improper Intubation

180 – Improper Positioning

185 – Failure to Obtain Consent/Lack of Informed Consent

190 – Anesthesia Related – Not Otherwise Classified

Surgery-Related 210 – Failure to Perform Surgery

220 – Improper Positioning

230 – Retained Foreign Body

240 – Wrong Body Part

250 – Improper Performance of Surgery

260 – Unnecessary Surgery

270 – Delay in Surgery

280 – Improper Management of Surgical Patient

285 – Failure to Obtain Consent/Lack of Informed Consent

290 – Surgery Related – Not Otherwise Classified

Medication-Related 305 – Failure to Order Appropriate Medication

310 – Wrong Medication Ordered

315 – Wrong Dosage Ordered of Correct Medication

320 – Failure to Instruct on Medication

325 – Improper Management of Medication Regimen

330 – Failure to Obtain Consent/Lack of Informed Consent

340 – Medication Error – Not Otherwise Classified

350 – Failure to Medicate

355 – Wrong Medication Administered

360 – Wrong Dosage Administered

365 – Wrong Patient

370 – Wrong Route

380 – Improper Technique/Induction

390 – Medication Administration Related – Not Otherwise Classified

Intravenous & 410 − Failure to Monitor

Blood Products- 420 – Wrong Solution

Related 430– Improper Performance

440 – I.V. Related – Not Otherwise Classified

450 – Failure to Ensure Contamination Free

460 – Wrong Type

470 – Improper Administration

480 – Failure to Obtain Consent/Lack of Informed Consent

490 – Blood Product Related – Not Otherwise Classified

Obstetrics-Related 505 – Failure to Manage Pregnancy

510 – Improper Choice of Delivery Method

520 – Improperly Performed Vaginal Delivery

530 – Improperly Performed C-Section

540 – Delay in Delivery (Induction or Surgery)

550 – Failure to Obtain Consent/Lack of Informed Consent

555 – Improperly Managed Labor – Not Otherwise Classified

560 – Delay in Treatment of Fetal Distress (i.e., identified but treated in untimely manner)

570 – Retained Foreign Body/Vaginal/Uterine

575 – Abandonment

580 – Wrongful Life/Birth

590 – Obstetrics Related – Not Otherwise Classified

Treatment-Related 610 – Failure to Treat

620 – Wrong Treatment/Procedure Performed

630 – Failure to Instruct Patient on Self-Care

640 – Improper Performance of Treatment/Practice

650 – Improper Management of Course of Treatment

660 – Unnecessary Treatment

665 – Delay in Treatment

670 – Premature End of Treatment (Also Abandonment)

675 – Failure to Supervise Treatment/Procedure

680 – Failure to Obtain Consent/Lack of Informed Consent

685 – Failure to Refer or Seek Consultation

690 – Treatment Related – Not Otherwise Classified

Monitoring-Related 710 – Failure to Monitor

720 – Failure to Respond to Patient

730 – Failure to Report on Patient Condition

790 – Monitoring Related – Not Otherwise Classified

Biomedical 810 − Failure to Inspect/Monitor

Equipment/ 820 − Improper Maintenance

Product-Related 830 – Improper Use

840 – Failure to Respond to Warning

850 – Failure to Instruct Patient on Use of Equipment/Product

860 – Malfunction/Failure

890 – Biomedical Equipment/Product-Related – Not Otherwise Classified

Miscellaneous- 920 − Failure to Protect Third Parties (e.g., failure to warn/protect

Related from violent patient behavior)

930 – Breach of Confidentiality/Privacy

940 – Failure to Maintain Appropriate Infection Control

950 – Failure to Follow Institutional Policy or Procedure

960 – Other (Provide Detailed Description)

990 – Failure to Review Providing Performance

9c. Severity of Injury Code. Select only one − Select code for principal injury if several injuries are involved.

|  |  |
| --- | --- |
| Temporary: | 1. Emotional Only (e.g., fright, no physical damage) |
| 2. Insignificant (e.g., lacerations, contusions, minor scars, rash; no delay) |
| 3. Minor (e.g., infections, misset fracture, fall in hospital; recovery delayed) |
| 4. Major (e.g., burns, surgical material left, drug side effect, brain damage; recovery delayed) |
| Permanent: | 5. Minor (e.g., loss of fingers, loss or damage to organs; includes non-disabling injuries) |
| 6. Significant (e.g., deafness, loss of limb, loss of eye, loss of one kidney or lung) |
| 7. Major (e.g., paraplegia, blindness, loss of two limbs, brain damage) |
| 8. Grave (e.g., quadriplegia, severe brain damage, lifelong care or fatal prognosis) |
| 9. Death |

9d. Claim Disposition Code. Enter code representing the final disposition of the claim. (1) Settled by Parties\*; (2) Disposed of by a Court\*\*; (3) Disposed of by Binding Arbitration\*\*\*; (4) Suit Abandoned\*\*\*\*; (5) Claim Abandoned.

A code with an (\*) requires a "Settlement Code" as well.

A code with an (\*\*) requires "Court Information" to be completed as well.

A code with an (\*\*\*) requires a "Binding Arbitration Code" as well.

A code with an (\*\*\*\*) requires a "County of Circuit Court" and "Docket Number" as well.

9e. Settlement Code. (1) Before Filing Suit or Demanding Arbitration Hearing; (2) Before Trial or Hearing; (3) During Trial or Hearing; (4) After Trial or Hearing but Before Judgment or Decision/Award; (5) After Judgment or Decision but Before Appeal; (6) During Appeal; (7) After Appeal; (8) As a result of Review Panel or Non-Binding Arbitration\*\*; (9) As a Result of Mediation; (10) As a Result of High/Low Settlement\*\*\*.

A code with an (\*\*) requires a "Review Panel or Non-Binding Arbitration Code" as well.

A code with an (\*\*\*) requires all applicable "Court Information" except "Court Code".

9f. Review Panel or Non-Binding Arbitration Code. (1) Finding for Plaintiff; (2) Finding for Defendant.

9g. Binding Arbitration Code (1) Award for Plaintiff; (2) Award for Defendant.

**Court Information**

10a. Court Code. (1) Directed Verdict for Plaintiff; (2) Directed Verdict for Defendant; (3) Judgment Notwithstanding Verdict for Plaintiff (judgment for defendant); (4) Judgment Notwithstanding Verdict for Defendant (judgment for plaintiff); (5) Judgment for Plaintiff; (6) Judgment for Defendant; (7) Decision for Plaintiff on Appeal; (8) Decision for Defendant on Appeal; (9) Voluntary Dismissal; (10) Involuntary Dismissal; (11) All Other Actions.

10b. County of Circuit Court. County of Circuit Court where lawsuit occurred.

10c. Docket Number.

10d. Date of Award. (MM/DD/YYYY)

10e. Was the Circuit Court decision appealed? Y or N

If "Y", Describe the Result of the Appeal. (Maximum = 25 characters)

10f. Describe any Other Post Trial Motions. (Maximum = 25 characters)

10g. Economic Damages. Amount of economic damages awarded by the court. (whole dollar amounts only)

10h. Non-economic Damages. Amount of non-economic damages awarded by the court. (whole dollar amounts only)

10i. Liability Doctrine. Indicate whether liability was governed by the doctrine of joint and several liability (J) or whether liability was separate (S).

**Claim Payment Information**

11a. Total Direct Indemnity Paid/Payable by You Under this Policy on Behalf of this Insured/Defendant. (whole dollar amounts only)

11b. Economic Damages. If 9d Claim Disposition Code is (2) Disposed of by a Court, enter the amount that was paid/payable by you for economic damages, as indicated by the court award. This amount plus 11c. Non-Economic Damages must equal amount reported in 11a. Total Direct Indemnity Paid/Payable by You Under this Policy on Behalf of this Insured/Defendant. (whole dollar amounts only)

11c. Non-Economic Damages. If 9d Claim Disposition Code is (2) Disposed of by a Court, enter amount that was paid/payable by you for non-economic damages, as indicated by the court award. This amount plus 11b. Economic Damages must equal amount reported in 11a. Total Direct Indemnity Paid/Payable by You Under this Policy on Behalf of this Insured/Defendant. (whole dollar amounts only)

11d. Direct Loss Adjustment Expense Paid/Payable by You under this Policy to Defense Counsel. (whole dollar amounts only)

11e. All Other Allocated Loss Adjustment Expenses Paid/Payable by You for this Insured/Defendant for this claim, including filing fees, telephone charges, photocopy fees, expenses of defense counsel, etc. (whole dollar amounts only)

11f. Direct Indemnity Paid/Payable by You Under All Policies for this Insured/Defendant. (whole dollar amounts only)

11g. Other Indemnity Paid by or on Behalf of this Insured/Defendant. (whole dollar amounts only)

D) Deductibles paid by insured/defendant for this claim under this policy;

E) Indemnity paid under any excess limits policy issued by you;

R) Amount paid by insured/defendant under self-insured retention;

S) Amount you paid above any stop loss limit.

11h. Claimed Medical Expense. Amount of medical expense claimed by the plaintiff/injured party. (whole dollar amounts only)

11i. Claimed Wage Loss. Amount of wage loss claimed by the plaintiff/injured party. (whole dollar amounts only)

11j. Trial Type. If trial was started, indicate whether it was a bench trial (B) or jury trial (J).

(Source: Amended at 40 Ill. Reg. 16137, effective November 30, 2016)