**AGGREGATE EROSION REPORTING FORM (AEF-1)**

|  |  |  |
| --- | --- | --- |
| **Insured Information** | | |
| Health Care Provider Name and Current Address | | PA License Number |
| **Insurer and Policy Information** | | |
| Name of Insurer | | Policy Number |
| Policy Type: | Policy Limits: | |
|  | | |
| Policy Coverage Dates: \_\_/\_\_/\_\_\_\_ to \_\_/\_\_/\_\_\_\_ | | |
|  | | |
| **Paid Claim Information** | | |
| Full Case Caption (including venue and docket #) | | Mcare File # (if any) |
| Date of Occurrence:  \_\_/\_\_/\_\_\_\_ | | Date Claim Reported:  \_\_/\_\_/\_\_\_\_ |
|  | | |
| Brief Factual Summary | | |
| Date of Settlement/Judgment  \_\_/\_\_/\_\_\_\_ | |  |
|  | | |
| Date of Claim Payment:  \_\_/\_\_/\_\_\_\_ | | Amount of Claim Payment: |
| **Contact Person Information** | | |
| Contact Person: | | Telephone Number (with ext.): |
| Email address: | | Date Form Completed:  \_\_/\_\_/\_\_\_\_ |