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

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| --- |
| **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:\_\_/\_\_/\_\_\_\_  |