HOPA Health Organizations Protective Association
The reciprocal advantage

PRIVILEGED
Seeking Solicitor/Claim Advice
Prepared in anticipation of litigation.

CLAIM REPORTING FORM

Complete form and forward via a secure platform to HOPA's Claims Counsel mmoulton@hopa-advantage.ca AND Senior Claims Examiner dyarnell@hopa-advantage.ca. Items in red are MANDATORY fields.

INSURED INFORMATION

Insured		Contact	
Facility Name		Phone	
Address		Email	
Your File No.		Fax	

CLAIMANT INFORMATION

Claimant		☐ Patient ☐ Visitor Other	
Address		Represented by Counsel ☐ Yes ☐ No	
Phone		Contacted by Counsel ☐ Yes ☐ No	
Date of Birth		Counsel's Name	

WITNESS INFORMATION

Witness 1 Name		Witness 2 Name	
Address		Address	
Phone		Phone	
Note		Note	

INCIDENT INFORMATION

Date/Time (am/pm) of incident		Date Insured aware of incident	
Where did incident occur		Have records been secured ☐ Yes ☐ No Is claimant/patient aware of incident ☐ Yes ☐ No	
How did Insured become aware of incident?			
If claimant/ patient is unaware of incident, what is plan for disclosure			

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INCIDENT DESCRIPTION

Include as many facts as are known, including precise location, all involved departments and treatment providers, and all steps taken after the incident. Use additional sheet if necessary.

Digital Signature **Date**

For security purposes this form must be digitally signed. Signing will prompt you to save the document, after which it cannot be changed.

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