



Instructions: Complete form and forward via a secure platform to HOPA's Claims Counsel Matthew Brothers-Moulton (mbrothersmoulton@hopa-advantage.ca) and Claims Examiner Ismene Nayagar (inayagar@hopa-advantage.ca)

INSURED INFORMATION

Form with fields for *Insured, *Facility Name, *Address, Your File No., *Contact, *Phone, *Email, Fax

CLAIMANT INFORMATION

Form with fields for *Claimant, *Address, Phone, Date of Birth, * If Other, Represented by Counsel, Contacted by Counsel, Counsel Name

WITNESS INFORMATION

Form with fields for Witness 1 Name, Address, Phone, Note, Witness 2 Name, Address, Phone, Note

INCIDENT INFORMATION

Form with fields for *Date/Time, *Location, *When and how did insured become aware of incident?, *If claimant/patient unaware of incident, plan for disclosure?, *Have records been secured?, *Claimant/patient aware of incident?

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 Completed

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