

SUPPLEMENTAL CLAIM INFORMATION

APPLICANT'S INSTRUCTIONS:

- 1. Answer all questions. If the answer requires detail, please attach a separate sheet.
- 2. Supplement must be signed and dated by owner, partner or officer.
- 3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS SUPPLEMENT.
(PLEASE TYPE OR PRINT IN INK)

NOTE: This form is to be completed by Applicant who has been involved in any claim or suit or is aware of an incident which may give rise to a claim. COMPLETE ONE FORM FOR EACH CLAIM/SUIT OR INCIDENT.

- 1. Applicant Name _____
- 2. Claimant Name _____
- 3. Name of Individual(s) at your firm/Company involved in Claim: _____
- 4. Indicate whether: _____ Claim/Suit _____ Incident
- 5. Date of alleged error: _____ Date claim made against applicant: _____
- 6. Additional defendants: _____
- 7. Current Disposition of claim:
 - DISMISSED (Action dropped without any payment to claimant or Statute of Limitations has expired)
 - ABANDONED (no activity from claimant for over 3 years)
 - WON by defense
 - WON by claimant Total Paid \$ _____ Amount Paid on your behalf \$ _____
 - Indicate whether : Court judgment, or Out of court settlement
 - OPEN Claimant's settlement demand \$ _____
 - Defendant's offer for settlement? \$ _____ Insurer's loss reserve \$ _____
- 8. Name of Insurer: _____
- 9. Description of claim: (Provide enough information to allow evaluation, and use reverse side if additional space is required.)
 - a. Alleged act, error or omission upon which Claimant bases claim: _____
 - _____
 - b. Description of cases and events: _____
 - _____
 - c. Description of the type and extent of injury or damage allegedly sustained: _____
 - _____
 - d. If a medical claim provide type of injury claimed:
 - Emotional Only Temporary Disability Death Cosmetic
 - Permanent Disability Other (describe) _____
- 10. Explain what action has been taken by you to prevent recurrence of the same type of claim. _____
- _____

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same warranty and conditions.

Name of Applicant*

Title (Officer, partner, etc.)

Signature of Applicant

Date

*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete this insurance.