

**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.