



### CLAIM SUPPLEMENTAL APPLICATION

Please read this entire Supplemental Application carefully before signing. Whenever used in this Supplemental Application, the term "Applicant" means the Named Insured(s). Please complete ONE Supplemental Application for EACH claim or incident.

Name of Applicant: \_\_\_\_\_

1. Name(s) of Claimant(s) or potential Claimant(s): \_\_\_\_\_

2. Name of Defendant(s) or potential Defendant(s): \_\_\_\_\_

3. Indicate: Incident (potential claim)      Claim      Lawsuit

(a) Date of alleged wrongful act, error or omission: \_\_\_\_\_

(b) Date Applicant became aware of the alleged wrongful act, error or omission: \_\_\_\_\_

(c) How did the Applicant become aware of the alleged wrongful act, error or omission: \_\_\_\_\_

4. Has the matter been reported to the current carrier:      Yes      No

Carrier Name : \_\_\_\_\_

Date Reported: \_\_\_\_\_

5. This matter is      Open      Closed

(a) If Closed, indicate the Total:

(1) Expense paid: \$ \_\_\_\_\_

(2) Damages paid: \$ \_\_\_\_\_

(b) If Closed indicate if:      Court Judgment      Out of Court Settlement      Withdrawn

(c) If Open, indicate the Claimant Settlement Demand, if any: \$ \_\_\_\_\_

(d) If Open, indicate the Settlement amount offered by the Applicant: \$ \_\_\_\_\_

(e) If Open, indicate the amount of legal expenses paid to date: \$ \_\_\_\_\_

(f) If Open, indicate the Insurer's reserve for:

(1) Expenses: \$ \_\_\_\_\_

(2) Damages: \$ \_\_\_\_\_

6. Provide a detailed description of the claim or incident, including the allegations against the Applicant:

7. Please explain the corrective actions taken to prevent a similar claim or incident from reoccurring:

8. Attach a loss history report covering the last five (5) years if available

By signing this Supplemental Application, the Applicant understands and agrees that the information submitted herein and all attachments becomes a part of, is deemed attached to, and is subject to the same representations and conditions of, its application for professional liability insurance.

This Supplement Application must be signed and dated by a Principal, Partner, Managing Member or Senior Officer of the Applicant. Electronically reproduced signatures will be treated as original.

Applicant Organization: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date \_\_\_\_\_