

SUPPLEMENTAL CLAIM INFORMATION

INSTRUCTIONS:

1. This form is to be completed by an Applicant or Insured who has been involved in any claim or suit or is aware of an incident which may give rise to a claim.
2. **COMPLETE ONE FORM FOR EACH CLAIM OR INCIDENT.**
3. If space is insufficient to fully answer any question, attach a separate sheet.
4. Answer all questions completely. Do not leave any blanks.
5. **DO NOT ATTACH COPIES OF SUIT PAPERS UNLESS REQUESTED**
(PLEASE TYPE OR PRINT)

1. Full name of Applicant or Insured:

2. Full name of individual(s) or firm involved in the claim:

3. Full name of Claimant:

4. Indicate whether: CLAIM/SUIT, or INCIDENT

5. Date and location of alleged error:

6. Date of claim:

7. Name of Insurer responding to this claim, suit, or incident:

8. Policy Number:

Limit of Liability: \$ _____

Deductible: \$ _____

9. Date reported to Insurance Company:

10. Additional defendants:

11. IF CLOSED:

Defense costs paid by Applicant: \$ _____

Defense costs paid by Insurer: \$ _____

Damages/Settlement paid by Applicant: \$ _____

Damages/Settlement paid by Insurer: \$ _____

Indicate whether: COURT JUDGMENT or OUT OF COURT SETTLEMENT

Date of Settlement or Judgment: _____

12. IF PENDING:

Defense costs paid by Applicant to date: \$ _____
Defense costs paid by Insurer to date: \$ _____
Amount asked in complaint: \$ _____
Claimant's settlement demand: \$ _____
Defendant's offer for settlement: \$ _____
Insurer's current loss reserve: \$ _____

13. DESCRIPTION OF CLAIM, SUIT or INCIDENT:

a. Description of alleged act, error or omission upon which claim is based:

b. Description of the type and extent of injury or damage allegedly sustained:

c. Assessment of liability and damages, including estimated loss and defense expenses:

d. Current case status, including any important dates and/or deadlines (e.g. significant discovery or pleadings/motions deadlines, mediation or trial dates, etc.):

e. Explain what action has been taken to prevent reoccurrence of a similar claim:

Applicant understands the information submitted herein becomes a part of the Applicant's Lawyer Professional Liability Insurance Application or Renewal Application and is subject to the same representations and conditions.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECIEVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE: This supplement is attached to and forms a part of the Lawyers Professional Liability Insurance Policy Application and is subject to the same representations and conditions.

Must be signed and dated by a Partner, Principal, Director or Officer as duly authorized on behalf of the Applicant.

Signature of Partner, Principal, Director or Officer

Title

Date

Print Name: _____