CapSpecialty
A Community of Insurance Specialists

115 Glastonbury Boulevard, Suite 102
Glastonbury, CT 06033
Phone: 860-494-4975
Claims: 866-599-6098

☐ Capitol Indemnity Corporation
☐ Capitol Specialty Insurance Corporation

CapSpecialty.com/PL
eosubmissions@CapSpecialty.com

Errors & Omissions Supplemental Claim Form

Instructions:

1. This form is to be completed when the Applicant / Insured has been involved in any **Claim** or is aware of an incident which may give rise to a **Claim**. **Complete one form for each Claim or Incident.**
2. If space is insufficient to answer any questions fully, attach a separate sheet.
3. Attach copy of any suit papers or demand letter.
4. Sign and date completed form.

1.	Full name of Applicant:
2.	Full name of individual(s) or entity(ies) involved in the **Claim**:
3.	Additional defendant(s):
4.	Full name of Claimant:
5.	Indicate whether: ☐ **Claim** ☐ Suit ☐ Incident / Circumstance Only (no **Claim** or suit)
6.	Date and location of alleged act, error or omission:
7.	Amount of Damages Claimant is seeking: $
8.	Date reported to Insurance Company:
9.	What is the status of the **Claim**? ☐ Open / Pending ☐ Closed / Settled ☐ Incident / Circumstance Only
10.	**If Closed:** How was the **Claim** resolved? (e.g. was it settled or dismissed or was there a judgment against Applicant?)
11.	**If Open / Pending:**

If Claim:	**Date (mm/dd/yyyy)**
Suit Filed:	
Claim Received:	

Paid by	**Defense Costs**	**Loss / Compensatory Damages**
You – out of pocket	$	$
Insurance Company	$	$

a.	Claimant's settlement demand:	$	b.	Defendant's settlement offer (if any):	$
c.	Insured's Reserve Amounts:		d.	Amounts already spent defending the **Claim**:	
	Loss:	$		By you:	$
	Defense:	$		By the Insurer:	$

What is your best estimate of the:

e.	Likely settlement amount for this matter:	$
f.	Date when you expect the **Claim** to be resolved (mm/dd/yyyy):	

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12. Insurer(s) responding to this **Claim** or incident:

Name	Limits of Liability	Deductible
	$	$
	$	$
	$	$
	$	$
	$	$

13. Name and address of law firm defending you against the **Claim:**

14. Description of suit, **Claim** or incident, including the allegations involved, the potential size of injury and your response:

15. What action(s) have been taken to prevent reoccurrence of a similar **Claim**?

I declare that the information submitted herein is true to the best of my knowledge and it becomes a part of the Professional Liability Application. I understand that this Supplemental Claim Form is subject to the same provisions concerning representations and warranties as made in the Professional Liability Application and that an incorrect or incomplete statement could void coverage under any policy issued by the Company in reliance on this information.

Signature of authorized representative of Applicant | **Title**

Print name of authorized representative | **Date**