



Supplemental Claim Form

Instructions:

- 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.**
- If space is insufficient to answer any questions fully, attach a separate sheet.
- Attach copy of any suit papers or demand letter.
- 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: <input type="checkbox"/> Claim <input type="checkbox"/> Suit <input type="checkbox"/> Incident / Circumstance Only (no Claim or suit)																														
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">If Claim:</th> <th style="width: 40%;">Date (mm/dd/yyyy)</th> </tr> </thead> <tbody> <tr> <td>Suit Filed:</td> <td></td> </tr> <tr> <td>Claim Received:</td> <td></td> </tr> </tbody> </table>	If Claim:	Date (mm/dd/yyyy)	Suit Filed:		Claim Received:																									
If Claim:	Date (mm/dd/yyyy)																														
Suit Filed:																															
Claim Received:																															
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 ? <input type="checkbox"/> Open / Pending <input type="checkbox"/> Closed / Settled <input type="checkbox"/> Incident / Circumstance Only																														
10.	<p>If Closed:</p> <p>How was the Claim resolved? (e.g. was it settled or dismissed or was there a judgment against Applicant?)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Paid by</th> <th style="width: 35%;">Defense Costs</th> <th style="width: 35%;">Loss / Compensatory Damages</th> </tr> </thead> <tbody> <tr> <td>You – out of pocket</td> <td>\$</td> <td>\$</td> </tr> <tr> <td>Insurance Company</td> <td>\$</td> <td>\$</td> </tr> </tbody> </table>	Paid by	Defense Costs	Loss / Compensatory Damages	You – out of pocket	\$	\$	Insurance Company	\$	\$																					
Paid by	Defense Costs	Loss / Compensatory Damages																													
You – out of pocket	\$	\$																													
Insurance Company	\$	\$																													
11.	<p>If Open / Pending:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;">a.</td> <td style="width: 35%;">Claimant's settlement demand:</td> <td style="width: 15%;">\$</td> <td style="width: 5%;">b.</td> <td style="width: 35%;">Defendant's settlement offer (if any):</td> <td style="width: 15%;">\$</td> </tr> <tr> <td>c.</td> <td>Insured's Reserve Amounts:</td> <td></td> <td>d.</td> <td>Amounts already spent defending the Claim:</td> <td></td> </tr> <tr> <td></td> <td>Loss:</td> <td>\$</td> <td></td> <td>By you:</td> <td>\$</td> </tr> <tr> <td></td> <td>Defense:</td> <td>\$</td> <td></td> <td>By the Insurer:</td> <td>\$</td> </tr> </table> <p>What is your best estimate of the:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;">e.</td> <td style="width: 80%;">Likely settlement amount for this matter:</td> <td style="width: 15%;">\$</td> </tr> <tr> <td>f.</td> <td>Date when you expect the Claim to be resolved (mm/dd/yyyy):</td> <td></td> </tr> </table>	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:	\$	e.	Likely settlement amount for this matter:	\$	f.	Date when you expect the Claim to be resolved (mm/dd/yyyy):	
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:	\$																										
e.	Likely settlement amount for this matter:	\$																													
f.	Date when you expect the Claim to be resolved (mm/dd/yyyy):																														
12.	<p>Insurer(s) responding to this Claim or incident:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 35%;">Limits of Liability</th> <th style="width: 35%;">Deductible</th> </tr> </thead> <tbody> <tr> <td></td> <td>\$</td> <td>\$</td> </tr> <tr> <td></td> <td>\$</td> <td>\$</td> </tr> <tr> <td></td> <td>\$</td> <td>\$</td> </tr> <tr> <td></td> <td>\$</td> <td>\$</td> </tr> <tr> <td></td> <td>\$</td> <td>\$</td> </tr> </tbody> </table>	Name	Limits of Liability	Deductible		\$	\$		\$	\$		\$	\$		\$	\$		\$	\$												
Name	Limits of Liability	Deductible																													
	\$	\$																													
	\$	\$																													
	\$	\$																													
	\$	\$																													
	\$	\$																													
13.	Name and address of law firm defending you against the Claim :																														

Supplemental Claim Form

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 Application. I understand that this Supplemental Claim Form is subject to the same provisions concerning representations and warranties as made in the 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