Professional Liability/Medical Malpractice
Preferred • Standard • Non-Standard

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WARNING - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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.

SM 6236-01 (12/01)