

CLAIM INFORMATION SUPPLEMENT

Complete this supplement if any claims have been made or legal actions have been brought against you or your firm in the past five years (if renewal, within the last year), or if you or any member of your firm are aware of any circumstance that may result in a claim being made against the firm or any individual. COMPLETE ONE FORM FOR EACH CLAIM OR INCIDENT.

1. Full name of party making claim (claimant): _____

2. Role of claimant (e.g., owner, contractor, etc.) _____

3. Indicate whether _____ claim _____ lawsuit _____ incident only

4. Date of alleged error: _____

5. Date claim reported to you: _____

6. Description of claim/incident:

A. Alleged act, error or omission upon which claimant bases claim:

B. Description of events leading to claim:

7. Amount of damages claimed: _____

8. Additional defendants: _____

9. Name of insurer: _____

10. **If closed:**

Total deductible paid: \$ _____

Indicate total loss paid in excess of the deductible: \$ _____

Indicate total defense expenses paid in excess of the deductible: \$ _____

If Pending:

Claimant's Settlement demand: \$ _____

If suit filed, amount asked in complaint: \$ _____

Insurer's loss reserve: \$ _____

Defense expenses to date: \$ _____

11. Explain what action has been taken to prevent a recurrence of similar claim:

The undersigned represents that the statements set forth herein are true, complete and accurate and that there has been no attempt at suppression or misstatement of any material facts known, and agrees that this application shall become the basis of any coverage and a part of any policy that may be issued by the Underwriters.

X

Signature (Owner, Officer or Partner)

Applicant/Firm Name (Please Print)

Date