SUPPLEMENTAL CLAIM INFORMATION

1- Name of Claimant/Plaintiff ____________________
2- Date your alleged error occurred ____________________
3- Date you reported your claim to the Insurance Company ____________________
4- Name of the Insurance Company you reported the claim ____________________
5- Name the specific individuals of the applicant named in this claim ____________________
____
6- Name of other additional defendants named in this claim ____________________
____
7- What is the present status of the claim ☐ Closed ☐ Open

8- **If Closed Claim:**
a. What was the total amount of defense expense paid? ____________________
b. What was the total amount of loss expense paid? ____________________
c. What was the amount of your deductible? ____________________
d. What was the total amount of your deductible you paid? ____________________

9- **If Open Claim:**
a. What is the amount of defense expense paid to date? ____________________
b. What is the amount of loss expense paid to date? ____________________
c. What is the amount of your deductible? ____________________
d. What is the amount of your deductible paid to date? ____________________
e. What amount is the Claimant/Plaintiff requesting in Complaint/Suit? ____________________
f. What is your Insurance Company defense expense reserve? ____________________
g. What is your Insurance Company loss expense reserve? ____________________

10- Describe the case and events ____________________
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11- What action has been taken by the applicant to prevent this type of claim from occurring in the future? ____
____
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This Supplemental Claim form becomes a part of the Insurance Application and is subject to the same representations and conditions of the application.

____________________ ____________________
Signature of Owner, Partner, Director of Applicant **Date**