



Professional Liability
A Division of NSM Insurance Group
555 North Lane, Suite 6060
Conshohocken, PA 19428
P: 800-970-9778 F: 610-941-1004

Supplemental Claim Information Form

APPLICANT'S INSTRUCTIONS:

1. This form is to be completed if Applicant answered **Yes** to question 27.a., b., c., or d. on the application.
2. Complete one form for each claim or incident.
3. If space is insufficient to answer any question fully, use the reverse side of this page or attach a separate sheet. Answer all questions completely.

PLEASE TYPE OR PRINT

1. Named Insured: _____
2. A. Name of Individual(s) involved in the claim: _____
B. Name of Firm involved in the claim: _____
3. Additional Defendants: _____
4. Full name of Claimant: _____
5. To what Insurance Company did you report this claim or incident? _____

A. Date of alleged error: _____
B. Date reported: _____
C. Date you first received notice: _____
6. Present Status of Claim (Check One): In Suit Open Incident Closed
A. If Closed:
Total damages paid including Claim Expense and Deductible: \$ _____
Indicate whether: Court Judgment, or Out of court settlement
B. If Pending:
Amount asked in Summons: \$ _____
Claimant's settlement demand: \$ _____
Defendant's offer for settlement: \$ _____
Insurer's loss reserve:* \$ _____
Deductible: \$ _____
*Unknown is unacceptable. Please contact insurance company or defense attorney for a good faith estimate.
7. Description of claim: (Provide enough information to allow evaluation and attach a separate page if additional space is required.)
A. Alleged act, error or omission upon which Claimant bases claim: _____

B. Description of case and events: _____

C. Description of the type and extent of injury or damage allegedly sustained: _____

8. Have you changed policies or procedures as a result of this claim that will reduce the possibility of a similar occurrence? Yes No

If Yes, please describe. _____

APPLICABLE IN THE STATE OF NEW YORK:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FRAUD WARNING:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

I/We hereby understand that the information submitted herein becomes a part of the professional liability application and is subject to the same representations and conditions.

APPLICANT'S SIGNATURE: _____ DATE: _____
(Must be Signed by an Owner, Officer or Partner)

Agent's Name: _____ Agent's License Number: _____
(Applicable to Florida agents only.)