



CLAIM INFORMATION SUPPLEMENT

This form must be completed in its entirety for each claim or incident within the past five (5) years.

- 1. Name of Applicant/Insured:
2. Full Name of Individuals(s) Involved as Defendant(s) in Claim:
3. Additional Defendant(s):
4. Name of Claimant(s):
5. a. Indicate Type: Claim/Suit, Incident; b. Indicate Status: Open, Closed
6. a. Date Claim/Incident made against Applicant/Insured; b. Date Claim/Incident reported to Insurer; c. Name of Insurer Claim/Incident was reported to:
7. If Claim is Closed, answer a, b, & c below. If claim is Open, please go to Question 9.
8. If Claim is Open, answer each of the following (do not leave any blank):
9. Description of alleged act, error or omission upon which Claimant bases the Claim.
10. Explain what action has been taken to prevent a recurrence of a 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 supplemental application will be included in the basis of any coverage and a part of any policy that may be issued.

Signature of Owner, Officer or Partner

Date