

**LAWYERS PROFESSIONAL LIABILITY INSURANCE
CLAIM INFORMATION SUPPLEMENT**

Medmarc Casualty Insurance Company • PO Box 10809 • Chantilly, VA 20153-0809 • 800.356.6886 • 703.652.1300 • Fax 703.652.1389

Please complete this supplement for each claim or incident within the past five (5) years:

1. Full Name of Applicant/Insured Firm: _____
2. Full Name of Lawyer(s) Involved in Claim: _____
3. Name of Firm involved in Claim: _____
4. Additional Firm Participants: _____
5. Full Name of Claimant: _____
6. a. Indicate Type: Claim/Suit ☐ Incident..... ☐ b. Indicate Status: Open..... ☐ Closed..... ☐
7. a. Date Claim/Incident made against Firm: _____ b. Date Claim/Incident reported to Insurer: _____
c. Name of Insurer Claim/Incident was reported to: _____
8. Did Carrier (check one): a. Defend _____ b. Defend under a reservation of rights _____ c. Disclaim Coverage _____
9. If Claim is **Closed**, answer a, b, & c below. If claim is **Open**, please go to Question 10.
 - a. Out of Court Settlement: Yes ☐ No ☐ Date of Settlement: _____
 - b. Court Judgment: Yes ☐ No ☐ Date of Judgment: _____
 - c. Total defense costs paid: \$ _____ Total Indemnity paid: \$ _____ Deductible paid: \$ _____
10. If Claim is **Open**, answer each of the following (please do not leave any blank):
 - a. Claimants settlement demand: \$ _____
 - b. Defendants offer for settlement: \$ _____
 - c. Insurer's Loss Reserve: \$ _____
 - d. Insurer's Expense Reserve: \$ _____
 - e. Defense Expenses to date: \$ _____
11. Description of alleged act, error or omission upon which claimant bases the Claim. Include events leading to the Claim. **Please do not attach summons or complaint.** Use additional sheets for more details. _____

12. Explain what action has been taken to prevent a recurrence of a similar Claim. Use additional sheets for more details. _____

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, or which should have been known, and agrees that this application will be included in the basis of any coverage that may be issued by the Company.

Signature of Partner, Officer or Owner of Applicant Firm: _____ Date: _____

Print or Type Name: _____ Title: _____