



Name of Insurance Company to which **Application** is made (herein called the “**Insurer**”)

COVER-PROSM APPLICATION
SUPPLEMENTAL CLAIM INFORMATION

Submit one form for each claim or incident. If space is insufficient to answer any question completely, please use the Additional Information page attached to this application.

1. Full name of the Applicant Firm:
 2. Full name of the firm which reported the claim (if different from above):
 3. Full name of the claimant:
 4. Indicate whether: Claim/Suit Incident/Potential Claim
 5. Date / Period of alleged error:
 6. Date the claim was reported to the insurance carrier:
 7. Other parties against which this claim is made:
 8. This claim is: OPEN CLOSED
 9. If CLOSED, indicate the date closed:
 10. Please complete the following:
 - If claim is still open:**
 - a. Claimants settlement demand: \$
 - b. Defendant’s offer for settlement: \$
 - c. Insurance company’s loss reserve: \$
 - d. Deductible: \$
 - e. Loss and expenses paid to date: \$
 - If claim is closed:**
 - a. Loss paid in excess of deductible: \$
 - b. Expenses paid in excess of deductible: \$
 - c. Deductible: \$
 - d. Settlement reached via:

Court judgment	Formal mediation/Arbitration proceeding	Out of court settlement
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- Note: If information is not available, please provide a copy of the suit papers.**
11. Name of insurance company:
 12. Claim number:

13. Description of claim / incident:

a. Provide a full description of the engagement, the events leading up to the claim, allegation asserted, against your firm and the current status of the matter. Please indicate if the claimant was your client. **If no, fully explain claimant's relationship to client:**

b. Was an engagement letter used? Yes No

c. What action has your firm taken to prevent a recurrence of such a claim in the future?

d. Did this incident or claim follow or result from an action to collect fees? Yes No

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

I understand that the information submitted herein becomes a part of my Philadelphia Insurance Companies Cover-Prosm application and is subject to the same conditions as stated on the application.

Name (Please Print/Type)

Title (Must be Principal, Partner, or Officer)

Signature

Date

The above signed warrants that he/she is authorized and has the power to complete and execute this Application, including the Warranty Statement on behalf of the **Applicant** and their respective Directors, Officers or other insured persons.

Produced By: (Section to be completed by Producer/Broker)

Producer

Agency

Producer License Number

Agency Taxpayer ID or SS Number

Address (Street, City, State, Zip)

ADDITIONAL INFORMATION

This page may be used to provide additional information to any question on this application. Please identify the question number to which you are referring.

Signature

Date