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One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

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

EMPLOYED LAWYERS PROTECTION PLUS
SUPPLEMENTAL CLAIM FORM

This form is to be completed by an Applicant or Insured who has been involved in any claim or suit or is aware of an incident which may give rise to a claim. Submit one form for each claim or incident. If space is insufficient to answer any question completely, please attach a separate page to the application. DO NOT ATTACH SUIT PAPERS.

1. Full name of the Applicant : _____
2. Full name(s) of individuals(s) or firm involved in the claim: _____
3. Full name of the Claimant: _____
4. Indicate whether: ☐ Claim / Suit ☐ Incident / Potential Claim
5. Date and location of alleged error: _____
6. Date of the claim: _____
7. Additional defendants: _____
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. Limit of Liability: $ _____
F. Amounts paid to date: $ _____

If Claim is closed:

A. Total loss paid including deductible(s): $ _____
B. Expenses paid in excess of deductible: $ _____
C. Deductible: $ _____
D. Settlement reached via:
☐ Court Judgment ☐ Formal Mediation/Arbitration Proceeding ☐ Out of Court Settlement

11. Name of Insurance Company: _____
12. Claim Number: _____
13. Description of claim, suit or incident: **Please do not attach suit papers. Each question on the form must be answered completely.**

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14. Provide a full description of alleged act, error or omission upon which the claim is based:

15. Provide a full description of the type and extent of injury or damage allegedly sustained:

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

I understand that the information submitted herein becomes a part of my Philadelphia Insurance Companies Employed Lawyers Protection Plus Application and is subject to the same conditions as stated on the application.

Name (Please Print)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, CEO OR EXECUTIVE DIRECTOR)

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 Agent/Broker)

Agent: Agency:

Agency Taxpayer ID or SS No.: Agent License No:

Address (Street, City, State, Zip) :

ADDITIONAL INFORMATION

This section 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