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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

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

COVER-PRO[SM] 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. Claimant's 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

Note: If information is not available, please provide a copy of the suit papers.

11. Name of insurance company: _____

12. Claim number: _____

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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-Pro[sm] application and is subject to the same conditions as stated on the application.

Name (Please Print) _____ Title **(Must be Principal, Partner or Officer)** _____

Signature _____ Date _____

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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