

**LAWYERS PROFESSIONAL LIABILITY INSURANCE  
CLAIM INFORMATION SUPPLEMENT**

Medmarc Casualty Insurance Company • 14280 Park Meadow Drive • Suite 300 • Chantilly, VA 20151-2219 • 800.356.6886 • 703.652.1300

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

a. Out of Court Settlement:..... Yes  No  ..... Date of Settlement: \_\_\_\_\_  
b. Court Judgment:..... Yes  No  ..... Date of Judgment: \_\_\_\_\_  
c. Total defense costs 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: \_\_\_\_\_