



- o DEERFIELD INSURANCE COMPANY
- o ESSEX INSURANCE COMPANY
- o EVANSTON INSURANCE COMPANY
- o MARKEL AMERICAN INSURANCE COMPANY
- o MARKEL INSURANCE COMPANY

SUPPLEMENTAL CLAIM FORM FOR PROFESSIONAL LIABILITY INSURANCE

Full name of Applicant: _____

Provide details below for each claim, fact, circumstance or situation. If more space is needed, attach additional pages.

1. Date Claim Made: _____ Date of Alleged Error: _____
 Current Status/Date settled: _____ Claim, Suit or Incident: _____
 Claimant(s)/Plaintiff(s): _____
 Additional Defendant(s) (if any): _____
 Nature of Claim and Allegations: _____

Date Reported to Insurance Company and Name of Insurance Company: _____
 Amount Reserved (Loss/ Expense): \$ _____ /\$ _____ Amount Paid (Loss/Expense): \$ _____ /\$ _____

2. Date Claim Made: _____ Date of Alleged Error: _____
 Current Status/Date settled: _____ Claim, Suit or Incident: _____
 Claimant(s)/Plaintiff(s): _____
 Additional Defendant(s) (if any): _____
 Nature of Claim and Allegations: _____

Date Reported to Insurance Company and Name of Insurance Company: _____
 Amount Reserved (Loss/ Expense): \$ _____ /\$ _____ Amount Paid (Loss/Expense): \$ _____ /\$ _____

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of the application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by owner, principal, partner, executive officer or equivalent within 60 days of the proposed effective date.

 Name of Applicant

 Title

 Signature of Applicant

 Date