SHAND MORAHAN & COMPANY, INC.
MARKEL®
Ten Parkway North, Deerfield, IL 60015
(847) 572-6000 Fax (847) 572-6137
Underwriting Manager
A Markel Company

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

SUPPLEMENTAL CLAIM INFORMATION

APPLICANT'S INSTRUCTIONS:
1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Supplement must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS SUPPLEMENT.
(PLEASE TYPE OR PRINT IN INK)

NOTE: This form is to be completed by Applicant who has been involved in any claim or suit or is aware of an incident which may give rise to a claim. COMPLETE ONE FORM FOR EACH CLAIM/SUIT OR INCIDENT.

1. Applicant Name _____
2. Claimant Name _____
3. Name of Individual(s) at your firm/Company involved in Claim: _____
4. Indicate whether: _____ Claim/Suit _____ Incident
5. Date of alleged error: _____ Date claim made against applicant: _____
6. Additional defendants: _____
7. Current Disposition of claim:
   [ ] DISMISSED (Action dropped without any payment to claimant or Statute of Limitations has expired)
   [ ] ABANDONED (no activity from claimant for over 3 years)
   [ ] WON by defense
   [ ] WON by claimant Total Paid $_____ Amount Paid on your behalf $
   Indicate whether : [ ] Court judgment, or [ ] Out of court settlement
   [ ] OPEN Claimant's settlement demand $_____
   Defendant's offer for settlement? $_____ Insurer's loss reserve $_____
8. Name of Insurer: _____
9. Description of claim: (Provide enough information to allow evaluation, and use reverse side if additional space is required.)
   a. Alleged act, error or omission upon which Claimant bases claim: _____
   b. Description of cases and events: _____
   c. Description of the type and extent of injury or damage allegedly sustained: _____
   d. If a medical claim provide type of injury claimed:
      [ ] Emotional Only [ ] Temporary Disability [ ] Death [ ] Cosmetic
      [ ] Permanent Disability [ ] Other (describe) _____
10. Explain what action has been taken by you to prevent recurrence of the same type of claim. _____

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same warranty and conditions.

_____ _____
Name of Applicant* Title (Officer, partner, etc.)

_____ _____
Signature of Applicant Date

*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete this insurance.