GenStar

CLAIM INFORMATION SUPPLEMENT

PHYSICIANS AND SURGEONS

This Claim Information Supplement must be completed, signed and dated by the applicant for each claim, suit or circumstance reported on your application for insurance. All questions must be answered completely. If any question does not apply, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please attach a separate page. Use a separate form for each claim, suit, or circumstance.

Physician Information:

APPLICANT NAME:

Claim or Potential Claim Information:

CLAIMANT/PATIENT NAME:	**AGE:**	**SEX:**

DATE OF ALLEGED INCIDENT:	**DATE CLAIM WAS MADE OR SUIT BROUGHT:**
ADDITIONAL DEFENDANTS:	
INSURANCE CARRIER TO WHOM CLAIM/POTENTIAL CLAIM REPORTED:	

Claim Status:

☐ **DISMISSED**	☐ **DEFENSE VERDICT**	
☐ **PLAINTIFF VERDICT**	**TOTAL PAID $**	**PAID ON YOUR BEHALF $**
☐ **SETTLEMENT**	**TOTAL PAID $**	**PAID ON YOUR BEHALF $**
☐ **OPEN**		

SETTLEMENT DEMAND $	**SETTLEMENT OFFER $**	**LOSS RESERVE $**

(♦For all Paid & Reserve amounts, include both Indemnity and Expense dollars.)

Claim Description: **(Include allegation(s), acts, omissions or circumstances that relate to a professional service(s) leading up to the claim, and any other facts pertinent to the claim.)**

The applicant declares that the information contained in this CLAIM INFORMATION SUPPLEMENT is true and that no material facts have been suppressed or misstated. The applicant understands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations. The applicant understands that incorrect information could void coverage.

Signature:	Date:
Printed Name:	