COVERYS SPECIALTY INSURANCE COMPANY

CHIROPRACTOR PROFESSIONAL LIABILITY SUPPLEMENTAL CLAIM FORM

INSTRUCTIONS: Complete a SEPARATE Supplemental Claim Form for each actual/potential claim. Answer **EACH** question fully. *Attach a supplement when necessary to expand upon information in any one area below.*

1) Applicant's Name: _____

2) Full name of individual(s) or applicant who was/were involved/named in the claim: _____

_____

3) Additional Defendants/Others Involved: _____

_____

4) Full name of Claimant: _____

5) (a) Date of alleged error: _____ (b) Date claim was made: _____

6) To what insurance company did you report this claim? _____

7) Present status of claim (check one): Open/Incident ☐ In Suit ☐ Closed ☐ Unknown ☐

8) **If Closed:**
Total damages paid and outstanding (including deductible): _____
Total defense costs paid if known: _____ Date closed: _____

9) **If Open/Pending:**
a) Claimant's settlement demand: $_____ b) Insurer's Reserve: $_____
c) Defendant's offer for settlement: $_____ d) Amount paid to date: $_____
e) Amounts Unknown ☐

10) **Claim Classifications**: (Please check (✓) all that apply):

☐Negligent Treatment & Procedures	☐Wrongful Death	☐Falls with Injury
☐Blood Draw Injury	☐Burns	☐Infection Injury
☐Delayed Treatment & or diagnosis	☐Needle Sticks	☐Reposition / transfer
☐Negligent Hiring/credentialing/training	☐Abuse / Neglect	☐Communication Error
☐Failure to Monitor	☐Assault / Battery	☐Fraud / Misrepresentation
☐ Breach of Fiduciary Duty	☐Negligent Supervision	

11) Description of claim or incident. Please do not attach copies of papers, or instruct us to refer to file or contact Company representative. Details must be provided to allow an evaluation of the claim or incident. Provide case and events details *(please attach supplement if necessary)*: _____

_____

_____

12) What steps have been taken to prevent a similar claim? _____

_____

_____

Applicant understands the information submitted herein becomes a part of the Insurance Application and is subject to the same representations and conditions. This form must be signed and dated by the applicant for whom the coverage is requested.

Applicant's Signature: _____ Date: _____

Name of Agent/Producer: _____ License #: _____

Signature of Agent/ Producer: _____ Date: _____