GESTIONNAIRES D'ASSURANCES | SUM | STRATEGIC UNDERWRITING MANAGERS INC

A subsidiary of ONE80 INTERMEDIAIRES

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APPLICATION – **MEDICAL MALPRACTICE INSURANCE**

CORPORATE HEALTH PROVIDERS

Full Name of the Applicant: _____

Trading Name (if different from above): _____

Has the applicant ever engaged in a similar activity under a different name? ☐ Yes ☐ No

If Yes, please provide details: _____

Address: _____

_____

Phone: _____ Fax: _____ Email: _____

Website: _____

Practice / Trading address/es: _____
(if different from above) _____

_____

Phone: _____ Fax: _____ Email: _____

If cover is required for more than one location, please attach a list of all addresses.

1. A) PLEASE NAME THE ULTIMATE OWNER OR HOLDING COMPANY:

   _____

   B) PLEASE IDENTIFY ANY CORPORATE OR PRIVATE ENTITY OF NON-CANADIAN ORIGIN, THAT HAS ANY OWNERSHIP OR INTEREST IN EITHER THE APPLICANT OR THE APPLICANT'S ULTIMATE OWNER OR HOLDING COMPANY AND THEIR PERCENTAGE HOLDING.

   _____

   _____

   C) LENGTH OF CURRENT OPERATION BY PRESENT PARENT / OWNER: _____

2. A) PLEASE STATE THE APPLICANT'S TOTAL GROSS FEE INCOME / TURNOVER / GROSS RECEIPTS (EXCLUDING SALE OF GOODS):

   For the past Financial Year: _____

   Estimate for the current Financial Year: _____

   B) PLEASE STATE THE APPROXIMATE NUMBER OF PATIENTS / CLIENTS:

   During the applicant's last Financial Year: _____

   During the applicant's current Financial Year: _____

3. A) PLEASE GIVE A FULL DESCRIPTION OF THE APPLICANT'S BUSINESS ACTIVITIES FOR WHICH COVER IS REQUIRED (THIS MUST BE ANSWERED):

   _____

   _____

   _____

   _____

B) Please tick if the applicant is involved in any of the following and where indicated*, complete the relevant Addendum.

	% Total Income
☐ Assisted Conception Unit*	_____ %
☐ Autologous Blood bank	_____ %
☐ Clinical Research Establishment*	_____ %
☐ Health & Fitness Centre / Gym*	_____ %
☐ Industrial / Occupational Health & Safety*	_____ %
☐ Health Screening Centre / Mobile Unit*	_____ %
☐ Inoculation / Travel Centre	_____ %
☐ Medical Personnel / Employment Agency*	_____ %
☐ Medical teaching facility	_____ %
☐ Nursing teaching facility	_____ %
☐ Pathology Laboratory*	_____ %
☐ Repatriation &/or Ambulance Service*	_____ %

C) What, if any, substantial changes in the applicant's activities or major new developments are likely to occur within the next 12 months? Please give full details:

_____

_____

4. A) IS THE APPLICANT LICENSED AND REGISTERED IN ACCORDANCE WITH THE APPLICABLE REGULATORY BODY OR LAW TO PRACTISE THOSE PROCEDURES AT THE ADDRESS SPECIFIED ON PAGE 1 FOR WHICH INDEMNIFICATION IS REQUIRED?

☐ Yes ☐ No If No, please give full explanation why not:

_____

_____

B) Please identify the applicant's memberships or registration with Association or Professional Bodies or Licensing Authorities.

_____

_____

C) Has membership of or registration with such, ever been suspended, withdrawn, amended, declined or had conditions attached?

☐ Yes ☐ No If Yes, please give full details:

_____

_____

PLEASE NOTE THAT THIS POLICY IS DESIGNED TO COVER CLAIMS MADE AGAINST THE APPLICANT. If cover is also required for claims made against registered medical /dental practitioners for work performed for the insured, please supply a list of all such practitioners for whom coverage is required stating the name, D.O.B., qualifications and practice of each practitioner. In addition to this please confirm whether or not the practitioners are employed by the insured or self-employed.

5. DOES THE APPLICANT ENSURE AND RECORD THAT AT ALL TIMES ALL REGISTERED MEDICAL AND DENTAL PRACTITIONERS ARE MEMBERS OF A MEDICAL / DENTAL DEFENCE ORGANIZATION, RECOGNIZED BY THEIR NATIONAL MEDICAL / DENTAL ASSOCIATION, OR ARE OTHERWISE FULLY INSURED FOR THEIR OWN MALPRACTICE?

   ☐ Yes ☐ No If the answer is No, please refer to the Note above.

6. PLEASE STATE THE TOTAL NUMBER OF PERSONS INVOLVED IN THE FOLLOWING CAPACITIES:

	EMPLOYED BY THE APPLICANT	SELF-EMPLOYED		EMPLOYED BY THE APPLICANT	SELF-EMPLOYED
Non procedural Physicians:			Nurses - Day		
Psychiatrists			Nurses - Night		
Other _____			Pharmacists		
Surgeons:			Paramedics		
Cosmetic			Resident Medical Officers		
Orthopedic			Complementary Professionals		
Other _____			Supplementary Professionals		
Anesthetists			Auxiliaries - Day		
Obstetricians			Auxiliaries - Night		
Gynecologists			Counsellors		
Lab/Path Technicians			Directors/Partners/Principals		
Dentists			Clerical/Administration		
Midwives			Other (please specify):		
Nurse Anesthetists			_____		

7. ARE ANY COUNSELLING SERVICES MADE AVAILABLE TO PATIENTS? ☐ Yes ☐ No If Yes:

a) Please indicate in which of the following categories:

	NUMBER OF COUNSELLORS	EMPLOYED	SELF-EMPLOYED	NUMBER OF PATIENTS
Assisted Conception				
Drug/Alcohol Dependency				
Elective Cosmetic				
Elective T.O.P.				
Gender Reassignment				
HIV / HEP / STD				
Sterilization				
Other (please specify):				

b) Do all Counsellors hold appropriate qualifications?

☐ Yes ☐ No Please provide details:

_____

8. DOES ANY PERSON INVOLVED IN THE TREATMENT AND CARE OF ANY PATIENT SUFFER FROM ANY DISABILITY, TRANSMITTABLE DISEASES I.E. HEPATITIS, H.I.V. ETC. OR OTHER IMPEDIMENT WHICH MAY AFFECT THE PERFORMANCE OF HIS / HER PROFESSIONAL DUTIES OR PLACE PATIENTS / CLIENTS AT RISK?

☐ Yes ☐ No If Yes, what procedures are in place:

_____

_____

9. PLEASE STATE:

a) Total number of Day Care Beds: _____

Total number of Overnight Beds: _____

b) What, if any, percentage of patients / clients in the last year came from USA: _____%

c) What, if any, percentage of the patients / clients in the last year who may be residents in Canada, come from USA: _____%

10. A) DOES THE APPLICANT PROVIDE FACILITIES FOR THE STERILIZATION OF INSTRUMENTS IN ACCORDANCE WITH CURRENT GUIDELINES?

☐ Yes ☐ No If No, please provide details of what arrangements are in place for this:

_____

_____

If Yes, does the applicant ensure that effective cross-infection control methods are employed?

_____

B) DOES THE APPLICANT HAVE A PROTOCOL FOR NEEDLESTICK INJURIES?

☐ Yes ☐ No If No, please provide details:

_____

_____

11. PLEASE GIVE FULL DETAILS OF WHAT RECORDS ARE KEPT, WHERE AND HOW THEY ARE STORED AND FOR HOW LONG THEY ARE RETAINED:

_____

_____

_____

Please note that it is a requirement of this policy that all records are retained for a minimum period of 10 years, and in the case of minors, 10 years from majority.

IF THE APPLICANT REQUIRES COMMERCIAL GENERAL LIABILITY INSURANCE PLEASE COMPLETE THE FOLLOWING SECTION:

12. PREMISES LIABILITY – Please describe each location occupied by the Applicant:

ADDRESS	SQUARE FOOTAGE	OCCUPIED	TLL REQUIRED?	LIMIT
a)		☐ By Insured ☐ By Tenant ☐ Vacant /Idle	☐ Yes ☐ No	$
b)		☐ By Insured ☐ By Tenant ☐ Vacant /Idle	☐ Yes ☐ No	$
c)		☐ By Insured ☐ By Tenant ☐ Vacant /Idle	☐ Yes ☐ No	$
d)		☐ By Insured ☐ By Tenant ☐ Vacant /Idle	☐ Yes ☐ No	$

If Tenants Legal Liability is required for any location please provide C.O.P.E. details.

_____

_____

If any of the above premises, in whole or in part, are leased or rented to others, please confirm that evidence of premises liability insurance is obtained from all tenants. ☐ Yes ☐ No Please provide details.

_____

Are any premises outside of Canada? ☐ Yes ☐ No If Yes, Specify: _____

Please describe standard housekeeping and maintenance procedures:

_____

_____

Please describe any special features at any location such as docks, swimming pools, water bodies, allurements, recreational facilities, roads, bridges, railways, dams, trespass activity, transfer facilities or other unusual hazards:

_____

13. A) DO THE PREMISES COMPLY WITH CURRENT FIRE PRECAUTION/ PREVENTION REQUIREMENTS

☐ Yes ☐ No If No, give details:

_____

B) ARE STAFF INSTRUCTED AND KEPT REGULARLY APPRAISED IN FIRE AND EMERGENCY PROCEDURES? ☐ Yes ☐ No

C) DO THE PREMISES HAVE AN EMERGENCY ELECTRICAL SYSTEM? ☐ Yes ☐ No

14. OPERATIONS LIABILITY

Please fully describe each activity performed off premises by the Applicant including installations and service work: (Attach separate sheets if necessary)

	Operation (s)	Gross Annual Receipts
a)	_____	$ _____
b)	_____	$ _____
c)	_____	$ _____
d)	_____	$ _____
e)	_____	$ _____

Indicate if any of the above work is performed outside Canada (specify):

_____

_____

15. PRODUCTS LIABILITY

Products manufactured, imported and /or distributed by the insured or others . (Attach separate sheet(s) if necessary)

	(*Please specify*)	TYPE OF PRODUCT (*INDICATE IF MANUFACTURED OR DISTRIBUTED*)	GROSS ANNUAL SALES CANADA	USA	OTHER
a	This year		$	$	$
	Previous year		$	$	$
b	This year		$	$	$
	Previous year		$	$	$
c	This year		$	$	$
	Previous year		$	$	$

Indicate which of the above products are manufactured by others:_____

Please indicate name and location of these suppliers:

_____

_____

Does the Applicant enter into formal contractual agreements with its distributors, suppliers, assemblers, packagers, installers or other service providers? ☐Yes ☐No

If Yes, is a "Hold Harmless" clause in the Applicant's favour used? ☐Yes ☐No

Is evidence of liability insurance required from them? If Yes, specify limits: _____

16. CONTRACTUAL LIABILITY

List all contractual agreements where the Applicant assumes the tort liability of others (other than for a lease of premises, sidetracks, easements, and/or elevator maintenance agreements). (Please attach relevant clauses)

a) _____

b) _____

c) _____

17. CONTRACTORS PROTECTIVE

a) Cost of work Sub-Let: $_____

b) Type of work: _____

c) Is evidence of liability insurance collected from subcontractors? ☐Yes ☐No

If Yes, specify limits: $_____

Does the Applicant enter into formal contractual agreements with Sub-contractors? ☐Yes ☐No

If Yes, is a "Hold Harmless" clause in the Applicant's favour used? ☐Yes ☐No

18. ADVERTISING LIABILITY

a) Describe all radio, television, internet and publishing activities contemplated for the next twelve months:

_____

_____

b) What is the Applicant's advertising spend for the next twelve months $_____

c) Does the Applicant have a contract with an Advertising agency? ☐ Yes ☐ No

If Yes, do they provide insurance to protect their client's interest? ☐ Yes ☐ No

If Yes , please specify: _____

19. A) DOES THE APPLICANT PROVIDE FACILITIES FOR SAFE COLLECTION, STORAGE AND DISPOSAL IN ACCORDANCE WITH CURRENT GUIDELINES / LEGISLATION OF:

i) 'Sharps'? ☐ Yes ☐ No

ii) Dressings, clinical / surgical waste etc? ☐ Yes ☐ No

B) DOES THE APPLICANT ENSURE THAT THE FOLLOWING ARE SAFELY DISPOSED OF IN ACCORDANCE WITH CURRENT GUIDELINES / LEGISLATION:

i) all blood / blood products? ☐ Yes ☐ No

ii) all other waste? ☐ Yes ☐ No

20. NON-OWNED AUTOMOBILE LIABILITY

a) Number of employees using their automobile on company business:

Regularly #_____ Occasionally #_____

b) Estimated annual cost of hired automobiles: $_____

c) Estimated annual cost of automobiles operated under contract: $_____

(Please provide details):

_____

d) Is SEF 94 required? Limit: $_____ Deductible: $_____

e) Any inflammable, caustic or explosive substances carried? ☐ Yes ☐ No

If Yes, specify:

_____

f) Any Long Haul operations? ☐ Yes ☐ No

If Yes, please specify:

_____

PREVIOUS INSURANCE HISTORY

Please refer to your broker/insurance agent if you are in any doubt as to what is being asked of you in this section.

21. HAS THE APPLICANT PREVIOUSLY INSURED FOR PROFESSIONAL LIABILITY?

☐ Yes ☐ No If Yes, please provide:

Name of insurer: _____

Date the Policy expires: _____ Limit of Liability: $ _____

Deductible: $_____ Retroactive Date: _____

Basis of cover (claims made or occurrence based):_____

If No, please provide details:

_____

_____

22. HAS THE APPLICANT PREVIOUSLY INSURED FOR COMMERCIAL GENERAL LIABILITY?

☐ Yes ☐ No If Yes, please provide:

Name of insurer: _____

Date the Policy expires: _____ Limit of Liability: $ _____

Deductible: $_____ Retroactive Date: _____

Basis of cover (claims made or occurrence based):_____

If No, please provide details:

_____

_____

23. A) HAVE ANY CLAIMS EVER BEEN MADE TO THE KNOWLEDGE OF THE APPLICANT AGAINST THE APPLICANT, ANY BUSINESS PREDECESSORS, ANY OF THE PRESENT OR FORMER PARTNERS OR OFFICERS? ☐ Yes ☐ No

B) IS THE APPLICANT AWARE OF ANY ACT, ERROR, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM AGAINST THE APPLICANT OR ANY PREDECESSOR IN BUSINESS, OR ANY PRESENT OR FORMER PARTNER OR OFFICER? ☐ Yes ☐ No

If the answer to either 23 A) or 23 B) is Yes, complete the enclosed CLAIMS HISTORY FORM.

Note: THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 23 A) AND/OR 23 B) OR ANY ERROR, ACT, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM, OF WHICH THE APPLICANT HAS KNOWLEDGE PRIOR TO THE INCEPTION OF THE POLICY.

24. HAS ANY PARTNER, EXECUTIVE OFFICER, DIRECTOR OR PROFESSIONAL EMPLOYEE HAD THEIR LICENSE SUSPENDED, BEEN FINED OR REPRIMANDED DURING THE PAST FIVE YEARS?

☐ Yes ☐ No If Yes, please provide details:

_____

_____

_____

25. TO THE APPLICANT'S KNOWLEDGE, HAS ANY COMPANY DECLINED OR TERMINATED THE INSURANCE, FOR THE APPLICANT, ANY PRESENT PARTNER OR OFFICER OR FOR ANY PREDECESSOR IN THE BUSINESS, PAST PARTNERS OR OFFICERS?

☐ Yes ☐ No If Yes, please provide details:

_____

_____

_____

26. WHEN IS YOUR FISCAL YEAR END? _____

27. INSURANCE REQUIRED:

MEDICAL MALPRACTICE

Limits Options: $_____

$_____

Deductible Options: $_____

$_____

COMMERCIAL GENERAL LIABILITY FORM

CGL each occurrence Limit: $_____

Personal Injury and Advertising Injury Limit: $_____

Medical expense Limit (any one person): $_____

General Aggregate Limit: $_____

Products- Completed Operations Aggregate Limit: $_____

We hereby declare that the above statements and particulars are true and that we have not suppressed or misstated any material facts and we agree that this declaration shall be the basis of any binder or contract of insurance with the Insurance Company, and that the limits and deductibles as stated in the said binder or contract of insurance shall govern.

It is understood and agreed that the completion of this declaration does not bind the Insurance Company to the issue of the insurance nor the Applicant to the purchase of this insurance.

It is further understood and agreed that if, following submission of this application to the insurer and prior to the date requested for coverage to be effective, the Applicant becomes aware of any information which has a bearing on question 23 a) or 23 b) of this application, the Insurer shall be immediately notified in writing of such information.

Signature of Applicant: _____ Dated: _____

Print Name and Title: _____

BROKER NAME: _____

ADDRESS: _____

_____

_____

PHONE NO: _____

FAX NO: _____

EMAIL ADDRESS: _____

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ADDENDUM 1 – ASSISTED CONCEPTION

1. IF AN ASSISTED CONCEPTION UNIT IS MAINTAINED, PLEASE GIVE A FULL BREAKDOWN OF THE NUMBER OF CYCLES UNDERTAKEN:

   A.I.H. _____

   A.I.D. _____

   I.V.F. / E.T. / P. R.O.S.T. _____

   Frozen Embryo Replacement _____

   G.I.F.T. _____

   Others (please specify) _____

   _____

   _____

2. IS ALL DONOR SEMEN SCREENED, CRYOPRESERVED AND QUARANTINED IN LINE WITH CURRENT RECOMMENDATIONS? ☐ Yes ☐ No

ADDENDUM 2 – CLINICAL RESEARCH

1. PLEASE STATE FOR WHOM CLINICAL RESEARCH PROJECTS ARE UNDERTAKEN E.G. PHARMACEUTICAL AND OTHER MANUFACTURERS, CHARITIES, RESEARCH FOUNDATIONS.

   _____

2. DOES THE APPLICANT RECEIVE A FULL INDEMNITY FROM THEIR PRINCIPALS? ☐Yes ☐No

3. DO ALL VOLUNTEERS SIGN AN INFORMED CONSENT FORM? ☐Yes ☐No

4. IF DOUBLE BLIND STUDIES ARE UNDERTAKEN ARE VOLUNTEERS MADE FULLY AWARE OF THIS? ☐Yes ☐No

5. DO ANY TRIALS INVOLVE ANY FEMALE VOLUNTEERS OF CHILD-BEARING AGE?
   ☐Yes ☐No If Yes, please provide full details:

   _____

   _____

6. PLEASE STATE THE ANNUAL INCOME OR TURNOVER: _____

7. PLEASE STATE THE NUMBER OF TRIALS DURING THE LAST 12 MONTHS DETAILING THE NUMBER OF VOLUNTEERS IN EACH TRIAL:

   _____

   _____

8. PLEASE STATE THE ANTICIPATED NUMBER OF TRIALS WITH WHICH THE APPLICANT WILL BE INVOLVED DURING THE NEXT 12 MONTHS DETAILING THE NUMBER OF VOLUNTEERS IN EACH TRIAL:

   _____

   _____

9. DOES THE APPLICANT CONDUCT ANY FORMAL RESEARCH, TESTING OR EXPERIMENTAL ACTIVITIES IN THE FOLLOWING CATEGORIES: TRANSPLANT, HUMAN EMBRYO RESEARCH, SURGERY, ARTIFICIAL ORGAN, OBSTETRICS, GENETIC ENGINEERING? ☐Yes ☐No

   If Yes, please attach full details.

   _____

   _____

Please provide a copy of the applicant Volunteer Informed Consent Form and any indemnity referred to in question 2 above.

ADDENDUM 3 – HEALTH & FITNESS CENTRES

1. PLEASE STATE THE APPROXIMATE PERCENTAGE OF THE APPLICANT'S INCOME WITHIN THE FOLLOWING CATEGORIES:

   Gym / Exercise _____%

   Diet / Nutrition _____%

   Sunbeds / Solarium _____%

   Hairdressing _____%

   Beauty Therapy _____%

   Electrolysis _____%

   Ear Piercing _____%

   Other (please specify): _____

2. PLEASE STATE THE NUMBER AND TYPE OF COMPLIMENTARY THERAPISTS:

   _____

   _____

   PLEASE ENCLOSE A COPY OF ANY OR ALL QUESTIONNAIRES THAT CLIENTS MUST COMPLETE PRIOR TO TREATMENT. IF THERE IS NONE STATE "NONE". _____

ADDENDUM 4 – INDUSTRIAL/OCCUPATIONAL HEALTH

1. IS THE APPLICANT'S WORK SOLELY "IN-HOUSE" I.E. LIMITED TO OTHER DIVISIONS OR COMPANIES WITH COMMON OWNERSHIP TO THEMSELVES? ☐ Yes ☐ No

   If No, please give full details of other companies for whom work is undertaken:

   _____

   _____

2. PLEASE GIVE FULL DETAILS OF ANY OUTPATIENT OR OTHER MEDICAL FACILITIES MADE AVAILABLE TO STAFF:

   _____

   _____

3. IS HEALTH SCREENING MADE AVAILABLE? ☐ Yes ☐ No

   If Yes, please complete Addendum 5

ADDENDUM 5 – HEALTH SCREENING

1. PLEASE GIVE AN APPROXIMATE PERCENTAGE BREAKDOWN OF THE APPLICANT'S PATIENTS BETWEEN THE FOLLOWING CATEGORIES:

   a) Insurance Medicals _____%

   b) General Fitness Assessment _____%

   c) Well Woman/Well Man _____%

   d) A.I.D.S. testing _____%

   e) Other (please specify): _____% _____z

2. DOES THE APPLICANT HAVE C.A.T./M.R.I. SCANNERS OR SIMILAR?

   ☐ Yes ☐ No If Yes, please give details including date of purchase, details of any service contract or guarantee:

   _____

ADDENDUM 6 – MEDICAL PERSONNEL AGENCIES

1. WHAT ARE THE MINIMUM ACCEPTABLE QUALIFICATIONS AND YEARS OF EXPERIENCE IN RESPECT OF THE FOLLOWING?

   a) Nurses _____

   b) Midwives _____

   c) Other (please specify): _____

2. ARE ALL STAFF VETTED AND REFERENCES TAKEN UP?

   ☐ Yes ☐ No If No, please give full details:

   _____

   _____

3. DOES THE APPLICANT ENSURE THAT ALL NURSES AND MIDWIVES SUPPLIED BY THEM MAINTAIN MEMBERSHIP OF THE R.C.N. OR THE R.C.M. OR ARE OTHERWISE INSURED FOR MEDICAL PROFESSIONAL LIABILITY?

   ☐ Yes ☐ No

ADDENDUM 7 – PATHOLOGY LABORATORIES

1. DOES THE APPLICANT ADMINISTER ANY PATHOLOGY LABORATORIES IN MEDICAL ESTABLISHMENTS OUTSIDE THEIR OWNERSHIP? ☐Yes ☐No If Yes, please give full details:

   _____

2. WHAT PROCEDURES ARE IN PLACE TO ENSURE THAT RESULTS ARE PROMPTLY RECEIVED BY WHOM THEY WERE REQUESTED?

   _____

3. PLEASE GIVE A PERCENTAGE BREAKDOWN BY INCOME BETWEEN THE FOLLOWING:

   a) Human Pathology _____%
   b) Animal Pathology _____%
   c) Drug Testing _____%
   d) Other _____%

   e.g. Legionnaires/Salmonella etc. (please specify and give full details):

   _____

   _____

   Within (i) above please confirm what percentage, if any, of the applicant's income/turnover/gross receipts is derived from A.I.D.S. testing. If none state "NONE": _____

ADDENDUM 8 – REPATRIATION / AMBULANCE SERVICES

1. PLEASE STATE THE:

   a) Number of Ambulances in operation: _____
   b) Number of crew members per Ambulance: _____
   c) Minimum acceptable qualifications of crew members: _____
   d) Average number of routine trips to hospitals, nursing homes etc. per annum: _____

2. IS AN AIR AMBULANCE REPATRIATION SERVICE MAINTAINED? ☐Yes ☐No

   If Yes, please state:
   a) In which countries the applicant anticipates operating: _____
   b) The number of repatriations per annum: _____

3. DOES THE APPLICANT PROVIDE PRIVATE AMBULANCE OR FIRST AID AT PUBLIC EVENTS? ☐Yes ☐No

   If Yes, please give details of:
   a) The type and size of event for which services are provided:

   _____

   b) The number of events per annum: _____

CLAIMS HISTORY FORM

Applicant Name: ______________________________ Date: ____________________

Claimant Name: ______________________________

Project Name & Location: ______________________________

____

Date of Loss: ______________________________

Description of Claim:

____

____

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Project Name & Location: ______________________________

____

Date of Loss: ______________________________

Description of Claim:

____

____

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Project Name & Location: ______________________________

____

Date of Loss: ______________________________

Description of Claim:

____

____

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Project Name & Location: ______________________________

____

Date of Loss: ______________________________

Description of Claim:

____

____

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Project Name & Location: ______________________________

____

Date of Loss: ______________________________

Description of Claim:

____

____

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$