

PODIATRIC PHYSICIANS PROFESSIONAL LIABILITY APPLICATION SUPPLEMENTAL CLAIM FORM



Rockwood Programs, Inc.
4001 Miller Road
Wilmington, DE 19802-1999
Tel: 800-365-0816 • Fax: 302-764-9125
www.rockwoodinsurance.com

Complete a SEPARATE Supplemental Claim Form for each actual or potential claim. Answer EACH question fully.

1. Applicant's Name _____
2. Full Name of individual(s) or applicant involved in the claim _____

3. Additional Defendants _____
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
8. If Closed:
 - a) Total damages paid and outstanding (including deductible) \$ _____
 - b) Total defense costs paid \$ _____ c) Date closed _____
9. If Open/Pending:
 - a) Claimant's settlement demand \$ _____ c) Insurer's Reserve\$ _____
 - b) Defendant's offer for settlement ..\$ _____ d) Amount paid to date ...\$ _____
10. Description of claim or incident. *Provide details on a separate sheet. Please do NOT reference previous underwriting files or instruct us to contact Company representatives. Enough information must be provided to allow for a full evaluation of the claim or incident.*
 - a) What is claimant's basis for the allegation _____

 - b) Description of case and events _____

11. What steps have been taken to prevent a similar claim? _____

Signature of Podiatric Physician _____

Title _____