Professional Liability Claim Notification Form

| Insured Name | |
|------------------------------------|--|
| | |
| Policy Number | |
| | |
| Contact Person | |
| | |
| Contact Email | |
| | |
| Contact Phone | |
| | |
| | |
| Claimant Name | |
| | |
| Relationship to Insured | |
| | |
| | |
| Date of Incident | |
| | |
| Description of Incident | |
| | |
| | |
| Date Claim First Made Against You | |
| | |
| Description of Claim or Allegation | |
| | |
| | |

Actions Taken in Defense

| Other Insurers Notified | | |
|-------------------------|--|--|
| Additional Information | | |
| | | |
| | | |