ISBA MUTUAL INSURANCE
20 S. Clark St. | Ste. 800
Chicago, IL 60603-1826
(312) 379-2000 OFFICE
(312) 379-2049 FAX
ISBAMUTUAL.COM

11.13.2019

# NOTICE OF POTENTIAL CLAIM, CLAIM, SUIT, ARDC OR SUBPOENA

## INSTRUCTIONS

This form can be filled out and submitted online or printed and filled out by hand or the information supplied in narrative form. If not submitted online send this form and/or narrative to claims@isbamutual.com or fax to 312.379-2049.

### Claim*

***Claim** means a demand received for money or services, or the service of a suit or the initiation of an arbitration proceeding against the Insured firm or one of its members, that seeks damages arising out of an act, error or omission in rendering professional legal services including an act, error or omission of which the firm, or anyone associated with the firm is aware and which they know, or ought reasonably to have known, might give rise to a demand for money or services, or the service of suit or arbitration proceeding against the firm or one of its members.

**1. Name of the Insured Firm:**

**2. Policy Number (if known):**

**3.** Are you reporting receipt of subpoena or inquiry from a disciplinary body (ARDC)? ☐ No ☐ Yes
If "yes", send in subpoena or inquiry and skip to signature line.

**4.** Was claim* reported to another insurance company? ☐ No ☐ Yes
If "yes", what company and when reported:

**5.** Name of person or entity making **claim*** against Insured:

**6.** Date of alleged wrongful act:

**7.** What event occurred on the above date?

**8.** How Insured became aware of alleged wrongful act:

**9.** Name of Insured lawyer(s) involved in the **Claim*** or potential **Claim***:

**10.** Name(s) of additional potential defendants, other than Insured attorneys:

**11.** Name of firm or company on behalf of which the professional services were rendered if different then firm in #1:

**12.** Indicate type: ☐ Potential Claim* ☐ Claim* ☐ Suit If suit, send copy of complaint and indicate when served.

**13.** Did this **Claim*** or potential **Claim*** result from an action to collect fees: ☐ No ☐ Yes

**14.** Description of **Claim*** or potential **Claim***:

a. Alleged act, error or omission that caused the **Claim*** or potential **Claim***:

b. Description of the type and extent of injury or damage allegedly sustained:

| **15.** Explain what action has been taken to prevent a recurrence of a similar **Claim*** or potential **Claim***: |
|---|
| |

| **SIGNATURE** | |
|---|---|
| **Signature of Attorney reporting the claim (if not owner, officer or partner of firm)** | |
| **Name** | **Title** |
| | |
| **Signature:** | |
| **Date:** | |
| **E-mail Address:** | |
| **Phone Number:** | |

Required in addition to above signature.

| **SIGNATURE** | |
|---|---|
| **Signature of Owner, Officer or Partner of Insured Firm** | |
| **Name** | **Title** |
| | |
| **Signature:** | |
| **Date:** | |
| **E-mail Address:** | |
| **Phone Number:** | |