



8. If closed, what were the following amounts paid: \_\_\_\_\_ loss/indemnity  
 + \_\_\_\_\_ defense costs  
 - \_\_\_\_\_ deductible paid  
 = \_\_\_\_\_ total

9. Indicate whether payment in question 8 above was:  judgment  
 arbitration award  
 settlement

10. If pending: Insurer's last offer for settlement: \$ \_\_\_\_\_ Claimant's last demand: \$ \_\_\_\_\_  
 Deductible or retention amount: \_\_\_\_\_ Limits: \_\_\_\_\_  
 Name of defense counsel: \_\_\_\_\_ Costs incurred to date: \_\_\_\_\_  
 Company reported to: \_\_\_\_\_  
 Claim/file reference #: \_\_\_\_\_  
 Reserve amounts established by other than CNA: \_\_\_\_\_

11. As a result of this claim, have you made procedural or policy changes which will reduce the possibility of a similar occurrence?  YES  NO

If yes, describe: \_\_\_\_\_  
 \_\_\_\_\_

WARNING — ALASKA, CALIFORNIA, COLORADO, DELAWARE, FLORIDA, INDIANA, KENTUCKY, MINNESOTA, NEW HAMPSHIRE, NEW JERSEY, NEW YORK, OHIO, OKLAHOMA AND PENNSYLVANIA RESIDENTS ONLY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES, INCLUDING BUT NOT LIMITED TO FINES, DENIAL OF INSURANCE BENEFITS, CIVIL DAMAGES, CRIMINAL PROSECUTION AND CONFINEMENT IN STATE PRISON.

(APPLICABLE IN COLORADO. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OR REGULATORY AGENCIES.)

(APPLICABLE IN CALIFORNIA. FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.)

Name of Applicant/Named Insured (please print): \_\_\_\_\_

Name and position of authorized representative completing this form (please print):

\_\_\_\_\_  
 SIGNATURE OF OFFICER OR PARTNER OF FIRM Date

\_\_\_\_\_  
 PRINT NAME OF OFFICER OR PARTNER Position

Supplemental Claims Application must be signed by duly authorized proprietor, partner, member or officer of the firm.