

Instructions on submitting a Claim to RISC

The policy states that the Insured shall immediately forward to the Company every demand, notice, summons or other process received by the Insured or the Insured's representatives about any Claim.

If you have received any of the aforementioned items, you **must** take the following steps to submit a claim to RISC for a coverage determination.

In order for RISC to make a coverage determination, we request you send **copies** of the following documents (**please DO NOT send originals**):

- Completed and Signed Notice of Claim form;
- Signed Fraud Warning Notice (*applicable only to ID and KY licensees*);
- Lawsuit and/or demand letter;
- Copies of all correspondence related to this dispute;
- A copy of your transaction file; and
- Proof of your prior Errors and Omissions insurance if you have not been insured by Continental Casualty Company since the date of the transaction.

These documents can be mailed, faxed (if under 30 pages), or emailed to RISC. The appropriate address and numbers to use are the following:

U.S. Mail Delivery:

Claims Department
P. O. Box 6709
Louisville KY 40206-0709

Overnight Delivery:

Claims Department
4211 Norbourne Boulevard
Louisville KY 40207-4048

Fax Delivery (Under 30 pages)

(502) 896-6343

Email Delivery

claims@risceo.com

If you have questions on how to complete the Notice of Claim form you may call our office at 1-800-637-7319, Ext. 2.

NOTICE OF CLAIM FORM

TO ENSURE THAT THIS NOTICE OF CLAIM FORM HAS BEEN RECEIVED BY RISC, PLEASE CONTACT OUR CLAIMS DEPARTMENT AT 1-800-637-7319, Ext. 2. IF YOU HAVE NOT RECEIVED A RESPONSE TO THIS NOTICE WITHIN 3-5 BUSINESS DAYS.

PLEASE NOTE: BOTH PAGES OF THIS CLAIM FORM MUST BE COMPLETED (INCLUDING A SIGNATURE ON PAGE # 2) AND RETURNED TO RISC.

REALTY COMPANY LEGAL NAME:

DBA NAME: _____

PRINCIPAL BROKER'S NAME:

**DATE FIRST RECEIVED
 WRITTEN DEMAND:**

**IF LAWSUIT,
 DATE OF SERVICE:**

FIRM ADDRESS:

**DATE OF CONTRACT
 OR OTHER INSURABLE EVENT:**
 *

DATE OF CLOSING:
 *

PHONE # : () _____ **FAX #:** () _____
EMAIL ADDRESS: _____

* (IF THIS DATE PRECEEDS EFFECTIVE DATE OF THE GROUP POLICY, PLEASE PROVIDE PROOF OF YOUR INSURANCE FROM THIS DATE TO THE DATE YOU BECAME INSURED UNDER THE GROUP POLICY.

AGENT(S) WITH ABOVE NAMED FIRM INVOLVED IN SUBJECT TRANSACTION:	AGENT'S ROLE (i.e. listing, selling, property manager etc):	AGENT'S PHONE #	AGENT'S EMAIL ADDRESS
1. _____ NAME	1. _____	1. () _____ _____	1. _____
_____		() _____	
LICENSE #			
2. _____ NAME	2. _____	2. () _____ _____	2. _____
_____		() _____	
LICENSE #			

ADDRESS AND PHONE # OF ANY OF ABOVE NAMED AGENTS WHO ARE NO LONGER WITH ABOVE NAMED FIRM:

NAME OF CLAIMANT(S) / PARTY MAKING DEMAND:

SELLER(S) / LANDLORD(S) OF SUBJECT PROPERTY:

ADDRESS OF SUBJECT PROPERTY (INCLUDE STREET ADDRESS, CITY AND STATE):

WAS THERE ANY WRITTEN DEMAND FOR MONEY OR SERVICES PRIOR TO THE RECEIPT OF THIS DEMAND?

NO YES IF YES, PLEASE ATTACH COPY AND INDICATE DATE RECEIVED:

DO YOU OR YOUR FIRM HAVE OTHER ERRORS & OMISSIONS INSURANCE?

NO YES IF YES, PLEASE PROVIDE COPIES OF THE OTHER DECLARATION PAGE AND POLICY.

DO YOU OR YOUR FIRM HAVE ERRORS & OMISSIONS EXCESS LIABILITY INSURANCE:

NO YES IF YES, PLEASE PROVIDE COPIES OF THE EXCESS DECLARATOIN PAGE AND POLICY.

DO YOU OR YOUR FIRM HAVE GENERAL LIABILITY INSURANCE?

NO YES IF YES, PLEASE PROVIDE COPIES OF THE OTHER DECLARATION PAGE AND POLICY.

I HEREBY CERTIFY THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE TRUE AND I HAVE NOT OMITTED OR MISREPRESENTED ANY INFORMATION.

SIGNATURE

DATE

NAME AND TITLE (PLEASE PRINT)

THE COMPANY MUST RECEIVE WRITTEN NOTIFICATION FROM AN INSURED IMMEDIATELY AFTER CLAIM OR SUIT IS BROUGHT. THE INSURED SHALL IMMEDIATELY FORWARD TO THE COMPANY EVERY DEMAND, NOTICE, SUMMONS OR OTHER PROCESS RECEIVED BY THE INSURED OR THE INSURED'S REPRESENTATIVE. THE INSURED SHALL NOT ADMIT ANY LIABILITY, ASSUME ANY OBLIGATION, OR INCUR ANY EXPENSE EXCEPT WITH THE PRIOR WRITTEN CONSENT OF THE COMPANY. THE INSURED SHALL COOPERATE WITH THE COMPANY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A 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.

**MAIL TO: RICE INSURANCE SERVICES COMPANY, LLC
ATTN: Claims Department
P.O. BOX 6709
LOUISVILLE, KY 40206-0709**

FAX TO: (502) 896-6343

EMAIL TO: claims@risceo.com

STREET ADDRESS FOR OVERNIGHT PACKAGES: 4211 NORBOURNE BLVD., LOUISVILLE, KY 40207-4048

**NOTICE TO APPLICANTS
FRAUD WARNING**

TO BE ATTACHED TO ALL INSURANCE APPLICATIONS AND CLAIM FORMS FOR THE STATES LISTED BELOW.

Applicable in Idaho

Any person who knowingly and with the intent to Injure, Defraud, or Deceive any insurer files a Statement of Claim or an Application containing any False, Incomplete or Misleading information is Guilty of a Felony.

Applicable in Kentucky and New Jersey

Any person who knowingly and with intent to defraud any insurance company or other persons, files a 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, subject to criminal prosecution and civil penalties.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Oklahoma

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Applicable in Pennsylvania

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.

Applicable in Virginia

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TO BE ATTACHED TO ALL CLAIM FORMS FOR THE STATES LISTED BELOW.

Applicable in California

Any person who knowingly presents 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.

Applicable in Indiana

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A. 291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Applicant's Signature

Date