

ACCOUNTANTS PROFESSIONAL LIABILITY/
BUSINESS PERSONAL PROPERTY INSURANCE

Producer's Name: _____
Producer's Address: _____
Producer's License: _____

(CLAIMS-MADE BASIS)

APPLICATION

THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY. PLEASE READ CAREFULLY. NOTE: PLEASE TYPE OR PRINT LEGIBLY. ALL QUESTIONS MUST BE ANSWERED IN INK. Please continue responses on separate sheet whenever space on this application is insufficient. (ATTACH A COPY OF YOUR LETTERHEAD).

1. A) Full name of Applicant: (Show complete firm name) _____
Date Established _____

B) Principal Business Address: (Please list any secondary office(s) on a separate sheet).
Address: _____

City: _____ County _____ State _____ Zip _____

2. Business Phone: _____ Business Fax: _____

3. Applicant is: Individual Partnership Corporation
Other (explain) _____

4. Has the name of the Applicant been changed or has the Applicant merged with or acquired control of any other practice unit during the past five years? Yes No If "Yes", please provide details, including name of firm and number of accounts.

5. Detail of Staff:
(A) Please list owners, officers, CPAs, PAs and similarly Certified/Licensed Accountants. (Complete supplemental insured information sheet. INCLUDE BRANCH OFFICE[S].)

	Full Time	Part Time
(B) CPAs	_____	_____
(C) Public accountants, degreed accountants	_____	_____
(D) Non-degreed accountants, bookkeepers	_____	_____
(E) All other personnel	_____	_____
TOTAL STAFF	_____	_____

(F) If a solo practice, identify the back-up CPA for any extended absences _____

NOTE: ALL PER DIEM PERSONNEL WORKING MORE THAN 30 DAYS PER YEAR ARE TO BE CONSIDERED AND MUST BE INCLUDED IN THE ABOVE CATEGORIES.

6. Is the Applicant or any member of the Applicant licensed or operating as the following:
Lawyer Yes No Investment Advisor Yes No
Real Estate Agent/Broker Yes No Escrow Agent Yes No
Insurance Agent/Broker Yes No Financial Planner ** Yes No

** OPTIONAL COVERAGE AVAILABLE FOR QUALIFIED INSURED

If any of the above are indicated, attach details of services provided and professional liability insurance for this practice.
Please note: There is no coverage for these services.

7. Total gross billings in dollars: Last Fiscal year \$ _____ Estimated Current Year \$ _____

8. Provide the percentage of services rendered by the Applicant in each of the following disciplines and whether or not you use engagement letters.

		Yes	No			Yes	No
A) Audits	___%	<input type="checkbox"/>	<input type="checkbox"/>	J) Investment Advice*	___%	<input type="checkbox"/>	<input type="checkbox"/>
B) Review and Compilation	___%	<input type="checkbox"/>	<input type="checkbox"/>	K) Electronic Data Processing and Consultation***	___%		
C) Bookkeeping and Write Up Services	___%	<input type="checkbox"/>	<input type="checkbox"/>	TOTAL GROSS REVENUE PAST 12 MONTHS \$	_____		
D) Tax Engagements	___%	<input type="checkbox"/>	<input type="checkbox"/>	L) Development of Computer Software for Sale***	___%	<input type="checkbox"/>	<input type="checkbox"/>
E) Business Acquisition/Divestiture Evaluations and Projections	___%	<input type="checkbox"/>	<input type="checkbox"/>	TOTAL GROSS REVENUE PAST 12 MONTHS \$	_____		
F) Fiduciary Engagements that include handling of client funds or check writing	___%	<input type="checkbox"/>	<input type="checkbox"/>	M) Sale of Computer Hardware	___%	<input type="checkbox"/>	<input type="checkbox"/>
G) Acting as a Business Manager*	___%	<input type="checkbox"/>	<input type="checkbox"/>	N) S.E.C. or "Blue Sky" Securities Activities**	___%	<input type="checkbox"/>	<input type="checkbox"/>
H) Financial Planning***	___%	<input type="checkbox"/>	<input type="checkbox"/>	O) Special Investigation*	___%	<input type="checkbox"/>	<input type="checkbox"/>
I) Shelter Advice*	___%	<input type="checkbox"/>	<input type="checkbox"/>	P) Other Services (please specify)	_____	___%	<input type="checkbox"/>

***PLEASE ATTACH A NARRATIVE OUTLINING TYPICAL SERVICES.**
****PLEASE ATTACH A COMPLETE DETAIL OF ALL SUCH SERVICES.**
***** OPTIONAL COVERAGE FOR QUALIFIED INSURED. PLEASE COMPLETE ATTACHED SUPPLEMENT.**

9. Does or has the Applicant, any predecessor in business, or any enterprise wholly or partly owned by the Applicant or by the Applicant's principals, partners, directors or officers ever:

- A) Receive commissions, fees, reciprocity, or revenue for the sale or promotion of investment or tax shelters? Yes No
- B) Organize, arrange or procure investments, real estate, or tax shelters? Yes No
- C) Prepare projections for use in selling tax shelters or investments? Yes No
- D) Participate in the management of any investment partnership, limited partnership, or other investment venture? Yes No
- E) Make recommendations as to the sale of specific stocks, bonds or other investments? Yes No

If yes, to any of the above, please attach full details.

10. Indicate the percentage relative to the type of clients undertaken by the Applicant.(NOTE: Total must equal 100%)

Contractors	___%	Unions	___%	Non-profit Organizations	___%
Government	___%	Attorneys	___%	Religious Organizations	___%
Federal	___%	Cooperatives	___%	Manufacturers	___%
State	___%	Pension Funds*	___%	Professional Athletics*	___%
County/Local	___%	Financial Institutions***	___%	Health Care Organizations	___%
Entertainment*	___%	Investment Bankers	___%	Health Care Professionals	___%
Individuals	___%	Estates, Trusts	___%	Real Estate Developers	___%
Retail Operations	___%	Limited Partnerships	___%	Retirement Facilities	___%
Other (please specify) _____					
				Total	100%

***Please attach a narrative describing the type of services performed.**
***** OPTIONAL COVERAGE. PLEASE COMPLETE ATTACHED SUPPLEMENT.**

11. Does the Applicant provide any of the following fiduciary activities: (If yes, attach narrative.)

- A) Act under any written trust agreement? Yes No
- B) Act as a periodic trustee or fiduciary on any client's behalf but not under a written trust agreement? Yes No
- C) Control receipt or disbursement of any part of client's funds? Yes No
- D) Invest client funds or act in a decision making capacity with respect to client funds? Yes No
- E) Have power of attorney for any client other than with respect to tax returns? Yes No
- F) Are internal audit procedures or cross-checks of custodial accounts in place? Yes No
- G) Are client funds commingled with any other funds? Yes No

12. Does the Applicant perform any professional services for any client in which any member of the Applicant or their relatives own an equity or financial interest or serve as an officer, director, trustee or partner? If yes, complete Outside Interest Supplement. Yes No

13. List the Applicant's three largest clients.

WORK PERFORMED	% OF APPLICANT'S INCOME	*INDUSTRY GROUP	PUBLICLY TRADED
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: Industry Group is defined as general description of client's major business, i.e., retail clothing, auto part manufacturing, wholesale grocer, savings and loan, diversified conglomerate, individual trade union, etc.

14. Excluding trustees or receivers, do you have clients that are in receivership or bankruptcy? Yes No

IF "YES" ATTACH A STATEMENT PROVIDING ALL DETAILS.

15. Office Procedures:
- A) Is there a complete review of the report and work papers prior to the release of ALL financial statements by a Principal or Supervisor who was not involved in the engagement? Yes No
 - B) Are all certified financial statements and reports personally signed by an owner or officer? Yes No
 - C) Does the firm:
 - 1. Maintain a diary or tickler system to ensure tax filings are made on time? Yes No
 - 2. Require a written agreement setting forth the exact nature and scope of the work to be performed? Yes No
 - 3. Make sure that the written agreement clearly defines the distinction between audited and non-audited statements? Yes No
 - 4. Mark each page of such statement as "unaudited" and issue a disclaimer of opinion on or accompanying the statement? Yes No
 - D) Are large customers billed on a regular "pay-as-you-go" basis? Yes No

16. A) Does the Applicant delegate work to other accounting firms? Yes No If yes, state to whom, nature of work and the percentage of the Applicant's gross billings. Please provide representative copy of any hold harmless agreements.

- B) Do the other firms have errors and omissions insurance? Yes No If yes, provide name of insurance company, policy number, expiration date and limit of liability. _____

17. During the past five years, has the Applicant ever sued to collect fees?
If "Yes," please complete for each (USE SEPARATE SHEET IF NECESSARY).

TYPE OF WORK PERFORMED	FEE AMOUNT	CLIENT	DATE OF SUIT	OUTCOME	STILLA
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18. Has the Applicant or any Partner, Officer or Employee of the Applicant ever:
- A) Had his or her state accounting license suspended or revoked? Yes No
 - B) Been subject to any investigation by any state board of accountancy, AICPA or State CPA Society? Yes No
 - C) Been subject to disciplinary action by any state board of accountancy, AICPA or State CPA Society? Yes No
 - D) Been subject to reprimand or disciplinary action by any federal, state or local court, government agency or regulatory body? Yes No
 - E) Had a quality review under sponsorship of the AICPA, State CPA Society, or other professional association?
If "Yes," attach copy. Yes No

(If the answer to A., B., C., or D. is "Yes," explain on a separate sheet.)

19. Have any claims or suits involving accounting practice or any other professional services been made during the past ten years against (a) the applicant or predecessor in business, or (b) any partner, officer of employed accountant? Yes No
If "Yes," a Supplemental Claim Information form must be completed for EACH claim for your application to be considered.
20. After inquiry, does the Applicant, predecessors in business or any other person for whom coverage is requested, have knowledge of any actual or alleged act, error, omission or circumstance which may result in a claim being made against them or any other basis to reasonably anticipate a claim being made against them? Yes No
If "yes", attach statement providing full details.
21. Has the Applicant had any professional liability insurance application denied, policy canceled or policy not renewed during the past five years (other than the reason of a carrier leaving the market)? Yes No
22. A) Has the Applicant had any professional liability insurance during the past five (5) years? Yes No
If "Yes," list prior insurance: (PLEASE ATTACH A COPY OF YOUR CURRENT DECLARATIONS PAGE.)

EFFECTIVE DATE month/day/year

LIMIT OF LIABILITY
INSURANCE COMPANY

PREMIUM

DEDUCTIBLE

B) Retroactive date on current policy _____

C) Have you ever purchased an extended reporting period endorsement? (If "Yes," attach narrative.) Yes No

23. Does the firm carry a fidelity bond? Yes No

Limit _____ Expiration _____ Carrier _____

24. A) Desired Limit of Liability and deductible: (Claim expense within policy limit.)

Limit (per claim/policy aggregate):
\$100,000/\$100,000

\$100,000/\$300,000

\$250,000/\$250,000

\$250,000/\$500,000

\$500,000/\$500,000

\$500,000/\$1,000,000

\$1,000,000/\$1,000,000

\$1,000,000/\$3,000,000

\$2,000,000/\$2,000,000

Aggregate Deductible:

\$1,000

\$2,500

\$5,000

\$10,000

\$25,000

OTHER

Retroactive Date Desired:

Desired Effective Date of Policy:

B) Optional First Dollar Defense Coverage

THE APPLICANT AND FIRM ACCEPT NOTICE THAT ANY POLICY ISSUED WILL APPLY ON A "CLAIMS-MADE BASIS."

The undersigned is authorized by and acting on behalf of the Applicant and represents that all statements and particulars herein are true, complete and accurate and that there has been no suppression or misstatement of fact and agrees that this application shall be the basis of coverage and become a part of any Policy issued by the Company.

THE APPLICANT AND FIRM ACCEPTS NOTICE THAT THEY ARE REQUIRED TO PROVIDE WRITTEN NOTIFICATION TO THE COMPANY OF ANY CHANGES TO THIS APPLICATION THAT MAY HAPPEN BETWEEN THE SIGNATURE DATE BELOW AND ANY PROPOSED EFFECTIVE DATE.

THE APPLICATION MUST BE SIGNED BY AN OWNER, PARTNER, PRINCIPAL OR SHAREHOLDER.

Name of Firm

Signature

Date

Title

SIGNING THIS FORM OR TENDERING PREMIUM WITH THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THIS INSURANCE.

FLORIDA NOTICE: Any person who knowingly and with 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 of the third degree.

NORTH CAROLINA NOTICE: LEGAL DEFENSE COSTS WITHIN LIMITS - PLEASE READ YOUR POLICY CAREFULLY.

SUPPLEMENTAL INSURED INFORMATION

POSITION CODES: O- Owners, Shareholders or Directors of the Corporation A-Public Accountants
 P-Partners in a Partnership S-Sole Practitioner E-CPA Employee D-Per diem CPAs as employed by the applicant

Do you have any branch offices? Yes No If yes, where? _____

	Name	Position Code*	Licenses Held	Years in Practice	Professional Organizations
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____
6	_____	_____	_____	_____	_____
7	_____	_____	_____	_____	_____
8	_____	_____	_____	_____	_____
9	_____	_____	_____	_____	_____
10	_____	_____	_____	_____	_____
11	_____	_____	_____	_____	_____
12	_____	_____	_____	_____	_____
13	_____	_____	_____	_____	_____
14	_____	_____	_____	_____	_____
15	_____	_____	_____	_____	_____
16	_____	_____	_____	_____	_____
17	_____	_____	_____	_____	_____
18	_____	_____	_____	_____	_____
19	_____	_____	_____	_____	_____
20	_____	_____	_____	_____	_____
21	_____	_____	_____	_____	_____
22	_____	_____	_____	_____	_____
23	_____	_____	_____	_____	_____
24	_____	_____	_____	_____	_____
25	_____	_____	_____	_____	_____

(Use additional sheet if necessary)

(FAX

NAME: _____
COMPANY: _____
ADDRESS: _____
STATE, ZIP: _____
DATE: _____
NUMBER OF PAGES(incl. Cover): _____
* FAX TO: _____

PLEASE FAX THIS APPLICATION TO THE OFFICE THAT IS NEAREST YOU.

* Click the link below for a list of our offices and current fax numbers.

<http://www.qsr-insurance.com/qsr-fax.html>

ADDITIONAL COMMENTS:

