

This application is for a Claims-Made Insurance policy.
Please read the policy carefully. It contains important exclusions and conditions to your insurance coverage.
Please direct questions to YOUR AGENT.

Application instructions

- Answer each question completely. Do not use pencil. A principal of the firm must sign the application. Use whole numbers where percentages are indicated.
- We retain the right to decline coverage and return your payment if the answers to the questions do not meet the program underwriting standards.

1. Applicant Information

For Agent Use:
Agent Code: _____

Firm Name: _____
Date Firm Established: ____/____/_____
Contact Person at Firm: _____
Principle Business Address: _____
City: _____ State: ____ Zip Code: _____
Desired Effective Date: ____/____/____ Tel# _____ Fax# _____
E-Mail Address: _____

2. Check the limit of liability desired. A standard deductible of \$1,000 applicable to losses and expenses will be given
 \$100,000/\$200,000 \$250,000/\$500,000 \$500,000/\$500,000 \$1,000,000/\$1,000,000

3. Provide the number of Accounting Professionals who are currently engaged to perform accounting services for your firm. Include owners, partners and employees. _____

4. **Areas of practice:** Indicate the percent of gross revenues derived from each engagement type. Total of A and B must equal 100%. Please use whole numbers and include services in item B, even though these are not covered.

A. SERVICES COVERED	B. SERVICES NOT COVERED (Including but not limited to)		TOTAL
____ Bookkeeping service	____ Auditing	____ Computer Consulting	
____ Reviews *	____ Financial Planning	____ Fiduciary Services	A ____
____ Compilations	____ Securities Work	____ Other	+ B ____
____ Tax Engagements	____ Financial Institutions	____ TOTAL B	=
____ Tax Planning	____ Investment Advice		100%
____ TOTAL A	____ Management Adv. Services		

*Coverage is optional.

5. **Insurance History:** Has the applicant firm maintained claims-made accountants professional liability insurance during the past four (4) years? If "yes," provide insurance history for the last four (4) years below Yes No

Insurance Company	Policy Limits	Deductible	Policy Period (month /day/year)	Premium
	\$	\$	From ____/____/____ To ____/____/____	\$
	\$	\$	From ____/____/____ To ____/____/____	\$
	\$	\$	From ____/____/____ To ____/____/____	\$
	\$	\$	From ____/____/____ To ____/____/____	\$

6. What is your current professional liability insurance policy's prior acts date? ____/____/____

7. Has your firm ever purchased an extended reporting period endorsement or "tail" coverage? Yes No

If "Yes", provide term of the extended reporting period "tail policy": ____/____/____ to ____/____/____

8. Total gross revenues shown on your last filed tax return. \$ _____ (Do not include direct recovery of expenses.)

a. If newly established, provide estimated gross revenues for the current year. \$ _____

9. Has your firm or any past or present owner, partner, corporate officer or employee upon inquiry:
- a. Had a professional liability claim or suit brought against them within the past five years? Yes No
 - b. Been made aware of any circumstance that may result in a claim or suit? Yes No

If "Yes" to 9a or 9b, complete the Supplemental Claim Information below. Insurance cannot be bound until your application and this information are reviewed and approved by the insurance company.

10. Has your firm or any past or present owner, corporate officer or employee upon inquiry:
- a. Had a professional liability application denied, policy canceled or policy not renewed? Yes No
 - b. Ever been reprimanded or subject to any fine or criminal penalty related to professional services? Yes No

If "yes" to 10a or 10b, please provide full details on a separate sheet. Insurance cannot be bound until your application and this information are reviewed and approved by the insurance company underwriter.

Supplemental Claim/Incident Information: Please Indicate whether a: Claim /Suit Incident

- Full name of claimant _____
- Additional defendants _____
- Date of alleged error ___/___/___ Date you became aware of alleged error ___/___/___
- Date reported to Ins. Company. ___/___/___ Name of Insurance Company _____

If CLOSED: Date closed ___/___/___ Total amount paid \$ _____

♦ Of the total amount paid, how much was for legal expenses \$ _____

If PENDING: Please forward a copy of the suit papers OR answer all questions below:

- a. Claimant's settlement demand \$ _____ Defendant's offer for settlement \$ _____
- b. Insurer's loss reserve \$ _____
- c. Is claim in suit? Yes No If "Yes", amount asked in summons \$ _____
- d. Was an engagement letter used? Yes No

On your letterhead attach a brief description of the claim indicating the alleged error, type of engagement and alleged injury.

General Star National Company is an "admitted" or "licensed" insurer in all states except Connecticut (where General Star Indemnity Company is "admitted" or "licensed"), subject to the financial solvency regulation and enforcement, which applies to licensed companies. This insurance company participates in state insurance guarantee funds. **Arkansas Residents: The insurance company compensates us for placement of this insurance policy.**

The Accountants professional liability program has been organized as a purchasing group located and domiciled in Illinois, pursuant to legislation enacted by congress known as the Federal Risk Retention Act of 1986. You will automatically become a member of the Purchasing Group once your completed application has been approved and your premium payment has been received.

This only applies in the states of IL, DE, KY, SC, TX and VA.

FRAUD WARNING

DISTRICT OF COLUMBIA (DC) FRAUD WARNING

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KANSAS FRAUD WARNING:

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy, or a claim for payment or other benefit pursuant to an insurance policy commits a fraudulent act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

MAINE FRAUD WARNING:

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

VERMONT FRAUD WARNING:

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

FRAUD WARNING (all other states):

Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT. SHOULD A POLICY BE ISSUED IT WILL ATTACH TO THE POLICY.

<p>I declare that the information submitted herein is true to the best of my knowledge and becomes a part of my Professional Liability application. I understand that an incorrect or incomplete statement could void my protection. Completion of the application or tendering of premium does not bind coverage. The application is subject to company Underwriting guidelines.</p>		
Signature _____	Title _____	Date ____/____/____
<i>Must be signed by a principal of the firm</i>		

For Insurance Agent use only:	Agent Code _____	
Name of Agent _____		Tel # () _____
E-Mail address _____		Fax # () _____
Business Address _____		
City _____	St. _____	Zip Code _____
Licensed Broker <input type="checkbox"/> Yes <input type="checkbox"/> No		License # _____
Licensed Agent <input type="checkbox"/> Yes <input type="checkbox"/> No		License Exp. Date _____
Licensed surplus lines Broker <input type="checkbox"/> Yes <input type="checkbox"/> No		License # _____

