ACCOUNTANTS' PROFESSIONAL ENROLLED AGENTS LIABILITY INSURANCE APPLICATION (NO COVERAGE FOR ATTEST SERVICES)

CPA Mutual Insurance Company of America Risk Retention Group
Burlington, Vermont

This is an application for a "Claims Made" policy. If an insurance policy is subsequently issued, it will only apply to claims first made against the insured during the policy period.

All questions must be answered fully and truthfully. Misrepresentations on this application may provide a basis upon which to void the policy after issuance. CPA Mutual Insurance Company of America reserves any and all rights under law to void the policy based on such misrepresentations. Therefore, it is important that all questions are answered accurately and completely.

INSTRUCTIONS:
- ⇒ **Please read carefully all statements and questions on this application.**
- ⇒ **Answer all questions; if the answer is none, state "none."**
- ⇒ **If space is insufficient to answer questions fully, use separate sheets of paper.**
- ⇒ **Application must be signed and dated.**

Policy #_____ Renewal Date: _____

INSURED INFORMATION:

1. Name of Applicant: _____

2. Principal business address: _____
   Street County
   _____
   City State Zip Code

   a) Mailing Address: _____
   Street or P.O. Box City State Zip Code

   b) Contact Person: _____ Telephone (___)_____ Fax (___)_____
   e-mail: _____

   c) On your firm's letterhead, provide address(es) of all other locations.

3. Staff Size: a) As of the prior month-end closest to the date of this Application, number of full-time:
   1) proprietor(s), partner(s), and owner(s): _____
   2) number of CPAs [excluding those listed in (1) above]: _____
   3) number of all other professional staff [excluding those listed in (1) and (2) above]: _____
   4) number of all other full-time, administrative support staff [including leased employees]: _____

   b) Number of part-time equivalent retired partner(s), shareholder(s),owner(s) and/or other employees for whom you wish coverage, who provide professional services on behalf of the firm: *(Please complete the Supplemental Reporting Form, Page 4, and attach a listing.)* _____

   ****TOTAL STAFF *(includes all locations)*:** _____

****PLEASE NOTE: IF MORE THAN TEN TOTAL STAFF YOU ARE NOT ELIGIBLE FOR THIS PROGRAM**

4. Within the last year, has Applicant Firm sued to collect fees? ☐ Yes ☐ No
   If "Yes", please provide details.

   _____
   _____

Please return completed application to CPA Mutual Insurance Co., 4923 NW 43 Street, Ste. C, Gainesville, Fl 32606-4460 or fax to (352)240-7896. For questions, call (800)543-3029.

NATURE OF PRACTICE:

5. a) Provide Gross Cash Revenues (per income tax return) derived from the Applicant Firm's professional accounting services for the last fiscal period.

   Gross Billings $_____ Fiscal Period Ending Month _____ Year _____

   b) Percentage from largest client: _____% Services rendered:_____

   c) Percentage from 2nd largest client: _____% Services rendered: _____

6. Please provide the approximate percentage of your gross billings (fees) received from each of the following types of engagements for the last fiscal year.

		Percent
a)	Bookkeeping services:	%
b)	Compilation services:	%
c)	Tax engagements:	%
d)	Business and investment advice in general and including tax shelter syndication and tax shelter advice, business valuations, and projections:	%
e)	Fiduciary engagements including handling of clients' funds and check-writing responsibility:	%
f)	Management Advisory:	%
g)	Data Processing:	%
h)	All other (If more than 5%, list types of engagements included.):	%
	TOTAL	**100 %**

7. Within the last year, has your firm performed any professional services for any client in which any of your firm's partners [or partner's spouse] or shareholder [or shareholder's spouse] own an equity or financial interest of more than 10 percent or serves as an officer, director or partner? ☐ Yes ☐ No

   If "Yes," please give details, including the name of the client, percentage of equity or financial interest, the nature of the relationship, the amount of fees earned from the client during the past fiscal year, and the nature of the services provided: _____

   _____

8. Claims/Disciplinary Action:

   Has any member of the firm become aware of any claim or circumstance which may give rise to a claim, not previously reported? ☐ Yes ☐ No
   (*If "Yes", please complete Supplemental Reporting Form, Page 5.)*

9. a) Check **LIMIT(S) OF LIABILITY** desired. (Limit applies to each claim and in the annual aggregate and is subject to applicable deductible.)

   ☐ $100,000 ☐ $250,000 ☐ $500,000 ☐ $1,000,000

   Check **DEDUCTIBLE(S)** desired. (Per claim applies to both loss and expense):

   ☐ $ 1,000 ☐ $ 2,500
   ☐ $ 5,000 ☐ $10,000
   ☐ Other_____

10. Would you like an optional quote for Cyber Liability coverage? ☐ Yes ☐ No

If so, please complete Cyber Liability SUPPLEMENT on page 6.

I,_____, AUTHORIZED BY AND ACTING ON BEHALF OF THE APPLICANT AND ALL PERSONS OR CONCERNS SEEKING INSURANCE, HAVE READ AND UNDERSTOOD THIS APPLICATION. I DECLARE THAT, AFTER INQUIRY, ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, COMPLETE AND ACCURATE.

I UNDERSTAND THAT THESE STATEMENTS ARE MATERIAL TO THE ISSUANCE OF THE INSURANCE BEING APPLIED FOR AND DECLARE THAT THE APPLICANT HAS NOT OMITTED, SUPPRESSED, OR MISSTATED ANY FACTS. I UNDERSTAND THAT THIS APPLICATION FORMS THE BASIS OF ANY INSURANCE POLICY WHICH MAY BE ISSUED TO THE APPLICANT AND THAT IT SHOULD BE DEEMED INCORPORATED INTO AND BECOME A PART OF THE POLICY AS ISSUED.

I FURTHER UNDERSTAND THAT THE APPLICANT IS UNDER A CONTINUING DUTY TO ADVISE CPA MUTUAL INSURANCE COMPANY OF AMERICA RISK RETENTION GROUP OF ANY OCCURRENCE OR EVENT TAKING PLACE PRIOR TO THE ISSUANCE OF THE POLICY APPLIED FOR WHICH MAY RENDER INACCURATE, UNTRUE, OR INCOMPLETE ANY STATEMENTS MADE IN THIS APPLICATION AND DECLARE THAT ANY SUCH CHANGE WILL BE IMMEDIATELY REPORTED IN WRITING TO THE COMPANY. I ACKNOWLEDGE AND AGREE THAT THE APPLICANT'S SUBMISSION AND COMPANY'S RECEIPT OF SUCH WRITTEN REPORT PRIOR TO THE INCEPTION OF THE POLICY APPLIED FOR IS A CONDITION PRECEDENT TO COVERAGE. I FURTHER ACKNOWLEDGE THAT THE SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT TO PURCHASE THE INSURANCE APPLIED FOR.

Name of Proprietor, Partner, Shareholder, or Officer (Please type)	Title
Date	Signature

ALL QUESTIONS MUST BE ANSWERED FULLY
PLEASE ATTACH ALL SUPPLEMENTAL REPORTING FORMS.

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SUPPLEMENTAL REPORTING FORM

Calculation Worksheet
Full-Time Equivalent Employees

Question Number 3(b):

	By All Former Owners/ Partners*	By All Independent Contractors, Leased, Part-Time, Per Diem Employees*
Total Hours Worked During Most Recently Completed Calendar Year Divided by:	_____ = _____ (b) 2,080 hrs	_____ = _____ (c) 2,080 hrs
Full-Time Equivalents (Round to Nearest Whole Number):	_____ (b)	_____ (c)
(b) + (c) Equals:	_____	

* Not included as full-time owners or staff in Question 3(a) of application.

Note: Please list services provided by all Independent Contractors.

_____

_____

_____

I understand information submitted hereon becomes a part of my Professional Liability Insurance Application with CPA Mutual Insurance Company of America Risk Retention Group and is subject to the same terms and conditions.

Claims, Incidents, and/or Suits Involving Accounting Practice

(No coverage will be provided in any policy issued as a result of this application for any negligent act, error, or omission occurring prior to the inception date of the policy which was either reported to prior insurer or as to which Applicant and any insureds under the policy had a reasonable basis to believe that such negligent act, error, or omission was a breach of professional duty or might result in a claim. Therefore, any such negligent act, error, or omission described in response to this question should be reported to the Applicant's current professional liability insurance carrier.)

Question Number 8:

Please complete *one* form for *each* claim or incident. If space is insufficient to answer any question completely, attach separate sheet.

1. Full name of Applicant: _____

3. Full name of Claimant: _____

4. Indicate whether ☐ claim/suit or ☐ incident

5. Date of alleged error: _____

6. Date claim reported: _____

7. Additional defendants: _____

8. If closed, indicate total paid including expenses: $ _____

9. If pending:
   - Claimant's settlement demand $ _____
   - Defendant's offer for settlement $ _____
   - Insured's loss reserve $ _____
   - Deductible $ _____
   - If suit filed, amount asked in complaint $ _____

10. Name of insurer: _____

11. Description of claim:
    a) Alleged act, error, or omission upon which claimant bases claim: _____

    _____

    _____

    b) Description of events leading to claim: _____

    _____

    _____

    c) Was engagement letter used? ☐ Yes ☐ No

I understand information submitted herein becomes a part of my Professional Liability Insurance Application with CPA Mutual Insurance Company of America Risk Retention Group and is subject to the same terms and conditions.

Signature of Applicant _____ Date _____

SUPPLEMENTAL REPORTING FORM
Cyber Liability

Section One – Applicant

1. Number of Accountants/CPAs to be covered under endorsement: _____

2. Requested effective date (no backdating): _____

For questions 3-6, if the answer is "No", coverage cannot be bound as per the terms and conditions of this program. If you desire an indication outside the program, please provide details for the "No" answers.

3. Does your company employ firewall protection? ☐ Yes ☐ No

4. If your organization stores personal information on portable devices, including laptops, cell phones, PDAs, back-up tapes, USB thumb drivers and external hard drives, is such data encrypted to industry standards? ☐ Yes ☐ No

   If your organization does not store personal information on portable devices, check here: ☐

5. Does your company use anti-virus software on all desktops / portable devices and mission critical servers, and is it updated in accordance with the software provider's recommendations? ☐ Yes ☐ No

6. Does your company have a formal process to disable or restrict access to information systems upon termination of employees? ☐ Yes ☐ No

For Question 7, if the answer is "Yes", coverage cannot be bound per the terms and conditions of this program. If you desire an indication outside the program, please provide details for a "Yes" answer.

7. In the last five (5) years, have you experienced any claims or are you aware of any circumstances that may give rise to a claim that would have been covered by this Endorsement? ☐ Yes ☐ No

Section Two – Notice to the Applicant

A. The Applicant represents that the statements set forth herein are true and complete, and any documents submitted in connection with this application are true and complete.

B. The Applicant acknowledges that this application and any documents submitted in connection with this application are the basis of insurance and will be deemed attached to and made a part of the endorsement, should an endorsement be issued.

C. The Applicant further represents that, if the information supplied on this application changes between the date of the application and the inception date of the insurance (if an endorsement is issued), the Applicant will immediately notify the underwriter of such a change(s). The insurer may modify or withdraw coverage.

Signed: _____ Date: _____

Authorized signature of a Principal or Officer
(Must be signed and dated no more than 45 days prior to binding)

Print Name: _____

Title: _____