



A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

Name of Insurance Company to which Application is made (herein called the "Insurer")

ACCOUNTANTS PROFESSIONAL LIABILITY INSURANCE APPLICATION - FLORIDA

NOTICE: This professional liability coverage is provided on a claims-made basis; therefore, only claims which are first made against you, and reported to the Company, during the policy term, any subsequent renewal of this policy or any extended reporting period are covered, subject to policy provisions.

Please attach a sample of your letterhead to this application.

1. Name of the Applicant:

1a. Applicant Firm's Tax ID Number: Telephone Number:

2. The Applicant Firm is a(n): Individual Partnership Professional Association
Professional Corporation LLC or LLP Other:

3. Is the Applicant Firm engaged in the practice of accountancy? Yes No
If no, please contact your agent before proceeding.

4. Applicant Firm's principal location:

Address:

City: State: Zip Code:

5. Applicant Firm's mailing address:

Address:

City: State: Zip Code:

6. When was the Applicant Firm established? (Month/Day/Year)

7. If the Applicant Firm has been established less than six (6) years, please list: Not Applicable

A. Name of the Predecessor Firm: Date Formed: / /

Percent owned by the current members of the Applicant firm: %

What is the current status of the Firm: Dissolved Changed the firm name Continues to exist

B. Name of the Predecessor Firm: Date Formed: / /

Percent owned by the current members of the Applicant firm: %

What is the current status of the Firm: Dissolved Changed the Firm Name Continues to exist

To enter more information, please use the separate page attached to the application

8. Does your firm practice from additional offices? Yes No **If yes, please attach a copy of the letterhead for each satellite office.**

9. Please list the Applicant Firm's staff breakdown:

Number of full time equivalent CPA's: _____

Number of full time equivalent non CPA Accounting Professionals: _____

Number of full time equivalent support staff: _____

9a. Most recently ended fiscal year's revenue: \$ _____

Current fiscal year's projected revenue: \$ _____

10. Has any member of the Applicant Firm or any Predecessor Firm been the subject of a complaint, disciplinary action or reprimand by any state board, the SEC, I.R.S., governmental regulatory or tax authorities, or any accounting society? Yes No **If yes, please use the separate page attached to the application to provide an explanation.**

11. Does the Applicant Firm share office space with professionals/firms other than those listed in question eight(8)? Yes No **If no, skip to question 12**

11a. If the Applicant Firm shares an office with other professionals does your firm separate files, employ separate support staff and present itself as an independent practice to the public? Yes No

11b. The name of the professionals/firm with whom the Applicant Firm shares an office is:

12. Area of Practice: Please identify the Applicant Firm's areas of practice with the number representing the percentage of gross income derived from that area during the past year. **The total of these must be one hundred (100) percent and represent all areas of practice.**

Area of Practice	%	Engagement Letters Used	
		Yes	No
Public Company Audit *		Yes	No
Other Audit *		Yes	No
Other Attest/Assurance Services (Describe the services provided on a separate sheet)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Review		Yes	No
Compilation		Yes	No
Bookkeeping		Yes	No
Individual Tax		Yes	No
Business Tax		Yes	No
Consulting Services (Describe the services provided on a separate sheet)		Yes	No
Estate Tax		Yes	No
Fiduciary Services		Yes	No
Litigation Support		Yes	No
Securities Activities **		Yes	No
Forecasts/Projections		Yes	No
Business Valuations		Yes	No
Business Planning (Describe the services provided on a separate sheet)		Yes	No
Personal Financial Planning and Investment Advisory Services (Describe the services provided on a separate sheet)		Yes	No
Other (Describe the services provided on a separate sheet)		Yes	No

* **If any percentage is indicated, complete the Audit Engagements Supplement form No. 2**

** **If any percentage is indicated, complete the SEC Information Supplement form No. 3**

13. Have any individuals in the Applicant Firm, or any Predecessor Firm, in the past two (2) years provided these services to any financial institution client:

a. Regulatory, securities, or compliance services? Yes No **If yes, complete SEC Information Supplement No. 3**

b. Services for an institution in which an Applicant member held an equity or management interest? Yes No

c. Whose deposits are not insured by a government agency such as the FDIC or NCUA? Yes No

d. Which was either in its formative stage, or which has at any point since been insolvent? Yes No

e. For which they were an officer, director, or general counsel? Yes No

If any part(s) of question 13 are answered yes, complete Financial Institution Supplement form No. 4

14. How many suits for collection of fees have been filed by the Applicant Firm or Predecessor Firms during the past two (2) years? _____ How many of these suits have been resolved successfully? _____

Dollar amount of fee suits last year: \$ _____

Dollar amount of suits for the previous year: \$ _____

15. Has the Applicant Firm, or any Predecessor Firm ever conducted SEC services or audits for any publicly held companies? Yes No **If yes, please complete the Public Company Audit Supplement No. 5.**

16. Within the past six (6) years have any of the Applicant Firm's accountants served as a director, officer, or an employee of any client; owned an equity interest in any client; or does any client represent more than twenty-five (25) percent of the Applicant Firm's revenues? Yes No **If yes, please provide the following for each:**

Name of Client: _____
Nature of business: _____
Services provided: _____
% of Firm's revenue derived from the client: ___% Equity interest ___% Dollar Value of Interest\$ _____
Person holding a position for this client: _____ Title: _____

Name of Client: _____
Nature of business: _____
Services provided: _____
% of Firm's revenue derived from the client: ___% Equity interest ___% Dollar Value of Interest\$ _____
Person holding a position for this client: _____ Title: _____

To enter more information, please use the separate page attached to the application

17. Does any member of the Applicant Firm hold any professional license other than for accountancy?
 Yes No

Name of Individual: _____ Profession: _____

Annual income derived from profession: \$ _____ Insurance Carrier: _____

To enter more information, please use the separate page attached to the application

18. During the past six (6) years, has any insurer of the Applicant Firm, Predecessor Firm or Prior Firm canceled or refused to renew professional liability insurance for any reason other than the carrier's withdrawal from the market? Yes No

19. In the past three (3) years, has the Applicant Firm undergone any peer or quality review sponsored for the AICPA or any state society of CPA's? Yes No **If yes, the results were:**
 Unqualified Qualified, Modified or Adverse

20. After inquiry, are any individuals of the Applicant Firm aware of any professional liability claims made against them, the Applicant Firm or any Predecessor Firm in the past six (6) years, including those which may have been made against them while with a Prior Firm? Yes No **If yes, complete the Accountants Professional Claim Supplement form No. 1 for each incident.**

20a. After inquiry, are any individuals of the Applicant Firm aware of any actual or alleged act, error, omission, incident or circumstance, which might reasonably result in a claim against them, the Applicant Firm or against any members of a Predecessor Firm in the past six (6) years? Yes No **If yes, complete the Accountants Professional Claim Supplement form No. 1 for each incident.**

20b. Please advise the total number of events which are applicable under 20. or 20a.: _____

For all incidents listed in questions 20. or 20a., a separate Claim Supplement No.1 form must be completed.

21. Please provide the following information for the Applicant Firm's/Predecessor Firm's most recent professional liability policy:

Insurer: _____ Policy effective date: _____ Policy expiration date: _____
Per Claim Limit: \$ _____ Aggregate Limit: \$ _____
Deductible \$ _____ Premium: \$ _____

21a. Does the Applicant Firm's current policy have a retro-active date? Yes No
If yes, what is the date? _____

22. Please note that the coverage will be offered only at the company's election. Coverage terms offered are also subject to determination by the **Insurer**. Please indicate the limit and deductible for which you wish to receive a quotation:

Limits

- | | | |
|--|--|--|
| <input type="checkbox"/> \$100,000/\$300,000 | <input type="checkbox"/> \$1,000,000/\$1,000,000 | <input type="checkbox"/> \$3,000,000/\$3,000,000 |
| <input type="checkbox"/> \$250,000/\$500,000 | <input type="checkbox"/> \$1,000,000/\$2,000,000 | <input type="checkbox"/> \$4,000,000/\$4,000,000 |
| <input type="checkbox"/> \$500,000/\$500,000 | <input type="checkbox"/> \$2,000,000/\$4,000,000 | <input type="checkbox"/> Other: \$ _____ / |
| <input type="checkbox"/> \$500,000/\$1,000,000 | | \$ _____ |

Deductibles

- | | | |
|----------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> \$1,000 | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$20,000 |
| <input type="checkbox"/> \$2,000 | <input type="checkbox"/> \$7,500 | <input type="checkbox"/> \$25,000 |
| <input type="checkbox"/> \$2,500 | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> \$3,000 | <input type="checkbox"/> \$15,000 | |

23. Risk Management Contact: _____
Risk Management Email: _____

Risk Management's Phone: _____

REPRESENTATIONS: I/We affirm that the information contained here and in any addendum is true to the best of my/our knowledge and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I/We hereby authorize the release of claim information from any prior insurer to the Company or its representatives.

NOTICE

1. Any claim or incident:
 - a) reported on question 20, or 20a; or
 - b) of which any member of the applicant firm has knowledge prior to policy inception will not be afforded coverage under any policy which may subsequently be issued by and of the Philadelphia Insurance Companies.

2. Failure to report to your current insurance company any:
 - a) claim made against you during your current policy term; or
 - b) fact, circumstance or incident of which your accountants are aware, which may give rise to a claim BEFORE policy expiration, may create a lack of coverage.

FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that they/ them are an authorized representative of the Applicant and declares to the best of their knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.

*Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company

VIRGINIA APPLICANT: READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.

FRAUD NOTICE STATEMENTS

APPLICABLE IN FLORIDA 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.

NAME (PLEASE PRINT/TYPE)

TITLE

(MUST BE SIGNED BY THE PRINCIPAL, PARTNER, OR OFFICER)

SIGNATURE

DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER

(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER

(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)

ADDITIONAL INFORMATION

This page may be used to provide additional information to any question on this application. Please identify the question number to which you are referring.

Signature

Date