Producer's Name: ___________________________
Producer's Address: __________________________
____
Producer's License: __________________________

ACCOUNTANTS PROFESSIONAL LIABILITY/
BUSINESS PERSONAL PROPERTY INSURANCE

(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 INSUREDS

   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.

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

***PLEASE ATTACH A NARRATIVE OUTLINING TYPICAL SERVICES.**
****PLEASE ATTACH A COMPLETE DETAIL OF ALL SUCH SERVICES.**
*** OPTIONAL COVERAGE FOR QUALIFIED INSUREDS. 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
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ 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	DATE OF SUIT	OUTCOME	STILL A CLIENT

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? ❑ Yes ❑ No
If "Yes," attach copy.

(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?
If "yes", attach statement providing full details. ❑ Yes ❑ No

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):

		Aggregate Deductible:	
$100,000/$100,000	$100,000/$300,000	$1,000 $2,500	Retroactive Date Desired: _________________________________
$250,000/$250,000	$250,000/$500,000	$5,000 $10,000	Desired Effective Date of Policy:
$500,000/$500,000	$500,000/$1,000,000	$25,000 OTHER	_________________________________
$1,000,000/$1,000,000	$1,000,000/$3,000,000		
$2,000,000/$2,000,000			

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					
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(Use additional sheet if necessary)

Quaker Special Risk a division of the Quaker Agency Inc.

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: