

CPA Value Plan

THIS IS AN APPLICATION FOR A CLAIMS-MADE POLICY WHICH, SUBJECT TO ITS PROVISIONS, APPLIES ONLY TO THOSE CLAIMS WHICH ARE BOTH FIRST MADE AGAINST YOU AND REPORTED TO US IN WRITING DURING THE POLICY PERIOD. PLEASE READ THE POLICY CAREFULLY AND DISCUSS THE COVERAGE WITH YOUR INSURANCE AGENT OR BROKER.

Application

for AICPA Professional Liability Insurance

Eligibility:

1. A member of my firm is a licensed CPA..... True False
2. My firm's professional staff is three or fewer True False
3. My firm's gross annual revenues were less than \$400,000 in the last fiscal year True False
4. Firm owners or employees do NOT receive commissions for the referral, solicitation for sale, or sale of securities, insurance products or investments..... True False
5. Less than 51% of my firm's revenues are derived from audit engagements True False
6. Less than 51% of my firm's revenues are derived from management advisory services..... True False
7. Firm owners or employees do NOT have discretionary authority to invest client funds True False
8. My firm does NOT provide assurances as to the care received by an individual, or consult with clients on care options, or provide assistance with daily activities (sometimes referred to as CPA ElderCare Services) True False

During the Past Five Years:

9. My firm has NOT audited any publicly held clients True False
10. My firm has NOT prepared financial statements that have been used in any securities offerings whether public, private, registered or unregistered..... True False
11. My firm has had fewer than three claims, and the total amount paid or reserved on all claims is less than \$10,000..... True False
12. No firm owner or employee has been the subject of any disciplinary or regulatory investigation or inquiry; suspended from practice; or charged, indicted or convicted of any felony charge..... True False
13. No firm owner or employee is aware of any event, act, omission, fee dispute or circumstance that is or reasonably could be the basis for a claim True False
14. No firm owner or employee has had any professional liability insurance declined, canceled or non-renewed (*not applicable in MO*)..... True False

If you responded "True" to all statements above, your firm qualifies for CPA Value Plan. Please complete the information below and on the reverse side and return it as soon as possible. Once your application is received, we'll send you a personalized coverage and rate quotation.

This professional liability coverage is provided on a claims-made basis; therefore, only claims, which are first made against you and reported during the policy term, are covered, subject to the policy provisions.

Firm Information:

Firm Name: _____ Date Firm Established: _____

Address: _____ Desired Effective Date: _____

City: _____ State: _____ Zip: _____

Person to Contact: Mr. _____
 Ms. _____
 Mrs. _____ Fax: (_____) _____

Telephone: (_____) _____ Check here to receive your quote via fax.

E-mail Address: _____

- Yes, I would like to receive the monthly AICPA Insurance Programs E-Newsletter, occasional Risk Management Alerts, and other important information about risk management training opportunities, new products, and program-sponsored CPA events.



Please complete reverse side.

Nature of Practice:

- 1. Staff Size: Professionals Including Owners _____ Clerical _____
- 2. Gross Annual Revenues: Last Fiscal Year \$ _____ Estimated Current Fiscal Year \$ _____
- 3. Areas of Practice: Total of all items must equal 100%.
Tax _____% Management Advisory Services _____%
PFP/Investment Advisory Services _____% Information Technology _____%
Bookkeeping/Compilation _____% General Business Planning _____%
Review _____% Litigation Consulting _____%
Audit of Non-Public Clients _____% Other Assurance Services _____%
- 4. Does your firm use engagement letters on the majority of engagements Yes No
- 5. Within the past three years, has your firm undergone a peer, quality or voluntary tax practice review under the sponsorship of the AICPA, a state CPA society or other professional organization? Yes No
If "Yes," opinion rendered: Unqualified Modified Other
- 6. Has a member of your firm attended an AICPA Professional Liability Insurance Program Risk Management Seminar or webcast in the last three years? Yes No
If "Yes," most recent attendance: _____ / _____
Month Year
- 7. Is at least one member of your firm an active member of one of the following professional associations/sections? (Check all that apply.)
 AICPA State CPA Society PCPS Other _____
 Employee Benefit Plan Audit Quality Center Governmental Audit Quality Center
 Center for Audit Quality
- 8. Has your firm been claim-free for the past five years? Yes No
- 9. Does your firm currently carry accountants' professional liability insurance? Yes No
If "Yes," provide: Insurance Carrier: _____
Policy Expiration Date: _____ / _____ / _____ Prior Acts Date/Retroactive Date: _____ / _____ / _____
or attach a copy of the firm's current declarations page.

Coverage Selection:

Limits of Liability: (per claim/annual aggregate) \$1,000,000/\$2,000,000 \$500,000/\$1,000,000 \$250,000/\$500,000 \$100,000/\$250,000
Deductible (aggregate) \$0 \$1,000 \$5,000

The completion of this application or tendering of premium does not bind coverage. This application is subject to the underwriting rules of the insurance company.

FRAUD NOTICE WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may be subject to civil fines and criminal penalties. (For Colorado residents only: any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies). (For Hawaii residents only: for your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for a payment of a loss or benefit is a crime punishable by fines or imprisonment or both). (For New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation). (For Pennsylvania residents only: any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000). (For Tennessee and Virginia residents only: penalties include imprisonment, fines and denial of insurance benefits).

I have: Answered all questions to the best of my knowledge.

Applicant represents, after inquiry, that the information contained herein and in any attachments, supplemental applications or forms required hereby are true, accurate and complete, and that no material facts have been suppressed or misstated. Applicant acknowledges a continuing obligation to report to the Company as soon as practicable any material changes in all such information, after signing the application and prior to issuance of the policy, and acknowledges that the Company shall have the right to withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance based upon such changes. Further, Applicant understands and acknowledges that:

- 1) if a policy is issued, the Company will have relied upon, as representations: this application; and any supplemental applications; and any other statements furnished to the Company in conjunction with this application, all of which are hereby incorporated by reference into this application and made a part hereof;
- 2) this application will be the basis of the contract and will be incorporated by reference into and made a part of such policy.

Acknowledged that this application will be the basis of the contract should a policy be issued.

I acknowledge all of the above.

Signature of Applicant (must be signed by a principal of the firm)	Title	Date
--	-------	------

Agent Name: _____ License #: _____

Aon Insurance Services is a division of Affinity Insurance Services, Inc.; in CA, MN & OK, (CA Insurance License # 0795465) Aon Insurance Services is a division of AIS Affinity Insurance Agency, Inc. and in NH & NY is a division of AIS Affinity Insurance Agency. © 2008

CNA is a service mark registered with the United States Patent and Trademark Office.