



SMALL ACCOUNTANTS
PROFESSIONAL LIABILITY
INSURANCE APPLICATION

CPA Cover
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Submitted By Producer: _____
 Address: _____

 License No.: _____

- A) This application must be completed in full, including all required attachments, dated and signed by an Owner, Partner, Principal, Director, or Officer of the Applicant.
- B) Attach a separate exhibit with the question number if more space is required to answer a question.
- C) Application must be completed in ink or typed.
- D) Forward a copy of all letterheads used by the Applicant.

I. Applicant's General Information

- 1. Name of Applicant Firm (include all legal entities the applicant desires to have identified as a Named Insured):

- 2. Home Office Mailing Address: _____
- 3. Contact Person: _____
- 4. Phone: () _____ Fax: () _____ E-Mail Address: _____
- 5. Website Address: _____
- 6. Date Business Established: _____

If applicant has been in operation less than three years, please attach a detailed explanation and resumes for all proprietors, partners, or stockholders, or a summary of the Applicant profile, including the partners' employment history.

- 7. Current Ownership Structure/ Ownership History
Applicant is a:
 Sole Proprietorship LLP
 Corporation PC
 Partnership Other: _____
 LLC

- 8. a. Does the Applicant share office space with any other entity? Yes No
If Yes, complete Multiple Offices/Shared Office Space Supplement A.

9. Within the last five years have there been:
- a. Changes in the applicant's name? Yes No
 - b. Changes in applicant's ownership or principals? Yes No
 - c. Mergers / consolidations with / or purchases of other accounting firms or other business entity? Yes No

If yes to any of the above complete Mergers and Acquisitions Supplement D.

II. Personnel and Staffing Information

10. Please account for all full time and all part time personnel/staff. A part time person is an individual who works 20 hours or less in a week. Two part time individuals equate to one full-time person.

	CPAs	Non-CPAs	Total
Owners, Partners & Officers:			
Employed Accounting or Tax Professionals:			
Other Consulting Professionals (not included above):			
Administrative Staff:			
Total:			

III. Scope of Practice

11. Gross Annual revenue for the Applicant on an accrual basis:

Second Last Fiscal Year	Last Fiscal Year	Estimate for Current Fiscal Year	Projected Next Fiscal Year
FYE: / /	FYE: / /	FYE: / /	FYE: / /
\$	\$	\$	\$

12. Percentage of revenue from the Applicants largest clients or client groups:

Largest: _____ % Second Largest: _____ %

For those clients representing 15% of more of the Applicant's revenue, please list for each:

Type of industry, services performed, length of time as a client and describe how the firm maintains its independence.

IV. Areas of Practice

13. a. Provide the percentage of the last fiscal year’s gross annual billings derived from the following areas of practice:
 b. Check the box for those services for which Applicant uses client-signed engagement letters.

Tax			Special Services		
Business Tax	%	<input type="checkbox"/>	Fiduciary Responsibilities:		
Estate Tax	%	<input type="checkbox"/>	Business/Personal Management (Complete Supplement H)	%	<input type="checkbox"/>
Individual Tax	%	<input type="checkbox"/>	ERISA Fiduciary Responsibility (Attach description on separate sheet)	%	<input type="checkbox"/>
Accounting/Bookkeeping Consulting	%	<input type="checkbox"/>	Executor/Trustee (Complete Supplement I)	%	<input type="checkbox"/>
Business Investment Advice (Attach description on separate sheet)	%	<input type="checkbox"/>	Other Fiduciary Responsibilities (Complete Supplement I)	%	<input type="checkbox"/>
Computer-Related Services (Complete Supplement E)	%	<input type="checkbox"/>	Personal Financial Planning/Investment Advice (Complete Supplement J)	%	<input type="checkbox"/>
Litigation Support	%	<input type="checkbox"/>	SEC Work other than Audit or Tax (Complete Supplement K)	%	<input type="checkbox"/>
Management Consulting (Attach description on separate sheet)	%	<input type="checkbox"/>	Assurance Services (Complete Supplement I)	%	<input type="checkbox"/>
Projections & Forecasts	%	<input type="checkbox"/>	Other (Attach description on separate sheet)	%	<input type="checkbox"/>
Valuations	%	<input type="checkbox"/>	TOTAL ADDS TO 100%	100%	
Attestation					
Audit (Complete Supplement F for public companies or G for non-public companies)	%	<input type="checkbox"/>			
Review	%	<input type="checkbox"/>			
Compilation	%	<input type="checkbox"/>			

14. If you are a sole practitioner, providing audit services, have you made arrangements for another CPA to perform a cold review for those services?

Yes No

If yes, provide their name and address on a separate sheet. Advise if this CPA or another is designated to handle your client's deadlines in the event of your extended absence.

VI. Claims History

1. Within the past five (5) years, has the Applicant or any partner, officer, owner or employee:
- a. had their accounting license or authority to practice accounting revoked? Yes No
 - b. been subject to disciplinary action, or currently under review, by any state board of accountancy, AICPA or State Society? Yes No
 - c. been subject to any fine, reprimand, criminal penalty related to the performance of professional services? Yes No
2. During the past five (5) years, has any claim or notice of claim been made or suit brought against

the Applicant, its predecessor(s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors? Yes No

3. Is the Applicant, its predecessor (s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors aware of any fact, circumstance, situation, allegation, contention or incident which may result in a claim being made against the Applicant, its predecessor (s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors? Yes No

If Yes to any of the questions numbered 1 through 3, complete and attach Claims Supplement O.

It is understood and agreed that, without limiting any rights of the underwriter, if such knowledge or information exists, any claim arising therefrom is excluded from this proposed insurance.

VII. Previous Coverage:

1. List Errors and Omissions carriers/information for the last 3 years. (If none, state "none").

Name of Carrier	Policy Period	Limits of Liability	Deductible	Premium	Retro Date
a). _____	_____	\$ _____ / \$ _____	\$ _____	\$ _____	_____
b). _____	_____	\$ _____ / \$ _____	\$ _____	\$ _____	_____
c). _____	_____	\$ _____ / \$ _____	\$ _____	\$ _____	_____

2. Has the firm ever purchased an extended reporting period endorsement? ("tail coverage")? Yes No

a. If yes, please provide effective date and expiration date:
 _____ / _____ / _____ to _____ / _____ / _____

3. Has any policy or application for Errors and Omission insurance on behalf of the Applicant, its predecessor(s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors ever been declined, cancelled or renewal refused within the last five (5) years? Yes No

If Yes, please provide an explanation: _____

VIII. Coverage Requested:

1. Limits of Liability: Please indicate the limit of liability desired:

PER CLAIM/ AGGREGATE FOR THE POLICY PERIOD	
<input type="checkbox"/> \$ 250,000/ \$ 250,000	<input type="checkbox"/> \$ 3,000,000/ \$ 3,000,000
<input type="checkbox"/> \$ 500,000/ \$ 500,000	<input type="checkbox"/> \$ 4,000,000/ \$ 4,000,000
<input type="checkbox"/> \$ 1,000,000/ \$ 1,000,000	<input type="checkbox"/> \$ 5,000,000/ \$ 5,000,000
<input type="checkbox"/> \$ 2,000,000/ \$ 2,000,000	<input type="checkbox"/> Other

2. Retention: Please indicate the retention desired:

Indicate your choice of a retention from the options listed below. The Insurer might require a higher retention and proof of financial ability to pay a retention. In selecting the retention, please remember that the retention applies to the payment of Loss and Defense Expenses.

RETENTION AMOUNT/EACH LOSS	
<input type="checkbox"/> \$ 1,000	<input type="checkbox"/> \$ 25,000
<input type="checkbox"/> \$ 2,500	<input type="checkbox"/> \$ 50,000
<input type="checkbox"/> \$ 5,000	<input type="checkbox"/> \$ 100,000
<input type="checkbox"/> \$ 10,000	<input type="checkbox"/> Other
<input type="checkbox"/> \$ 15,000	

3. Effective Date Requested: ____/____/____ 4. Retroactive Date Desired: ____/____/____

THE UNDERSIGNED AUTHORIZED OWNER, PARTNER, DIRECTOR, OR OFFICER AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE THE APPLICATION IS EXECUTED AND THE TIME THE PROPOSED INSURANCE POLICY IS BOUND OR COVERAGE COMMENCES, THE NAMED INSURED WILL IMMEDIATELY NOTIFY LONDON AMERICAN PROFESSIONAL LIABILITY LLC. IN WRITING OF SUCH CHANGES. LONDON AMERICAN PROFESSIONAL LIABILITY LLC. RESERVES ITS RIGHTS TO MODIFY OR WITHDRAW ITS PROPOSAL.

THE UNDERSIGNED AUTHORIZED OWNER, PARTNER, DIRECTOR, OR OFFICER REPRESENTS AND WARRANTS ON BEHALF OF THE NAMED INSURED AND ALL PERSONS/ENTITIES FOR WHOM INSURANCE IS BEING SOUGHT THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF AFTER DILIGENT INQUIRY, THE STATEMENTS SET FORTH HEREIN AND ATTACHED HERETO ARE TRUE. IT IS UNDERSTOOD THAT THE STATEMENTS IN THIS APPLICATION, INCLUDING MATERIALS SUBMITTED TO OR OBTAINED BY THE UNDERWRITER ARE MATERIAL TO THE ACCEPTANCE OF THE RISK, AND RELIED UPON BY THE UNDERWRITER.

NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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.

NOTICE TO DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND VIRGINIA APPLICANTS: 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 A DENIAL OF INSURANCE BENEFITS.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO NEW JERSEY APPLICANTS: 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 INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.

NOTICE TO OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

NOTICE TO PENNSYLVANIA APPLICANTS: 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 INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

APPLICANT UNDERSTANDS AND AGREES THAT THE COMPLETION OF THIS APPLICATION DOES NOT BIND THE COMPANY TO ISSUANCE OF AN INSURANCE POLICY.

Signature of Applicant: _____
(Must be signed by an Owner, Partner, Director, or Officer of the Named Insured. It is agreed the signer has authority to act on behalf of all insureds.)

Printed Name of Applicant: _____ Title _____

Date: _____