



This professional liability coverage is provided on a **claims-made** basis and underwritten by The Chicago Insurance Company. Simply follow the instructions for self-rating premium calculation and submit payment to request to bind coverage. All questions must be completed in ink and signed/dated by a principal of the firm. Mail or fax your completed application and payment to:

1. Firm Name \_\_\_\_\_  
 Contact Person \_\_\_\_\_

2. Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (     ) \_\_\_\_\_ Fax (     ) \_\_\_\_\_

3. Desired Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Firm Established: \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Coverage Selection: Check the limit of liability desired. A standard deductible of \$1,000 applicable to losses and expenses will be given. *Claim expenses outside the limits and loss only deductible mandatory in New York.*

\$100,000/\$200,000     \$250,000/\$500,000     \$500,000/\$500,000     \$1,000,000/\$1,000,000

5. Provide the number of Accounting Professionals who are currently engaged to perform accounting services for your firm (include owners, partners and employees) \_\_\_\_\_

6. Areas of practice: Indicate percent of gross revenues derived from each engagement type. Total of A and B must equal 100%. Please use whole numbers and include services in item B, even though these are not covered.

(A) Services Covered	(B) Services Not Covered (including but not limited to)	
_____ Bookkeeping Services	_____ Auditing	_____ Management Advisory Svcs.
_____ Reviews*	_____ Financial Planning	_____ Computer Consulting
_____ Compilations	_____ Securities Work	_____ Fiduciary Services
_____ Tax Engagements	_____ Financial Institutions	_____ Other
_____ Tax Planning	_____ Investment Advice	
_____ TOTAL A		_____ TOTAL B

\*Coverage is optional (see Premium Calculations - Item 4a on page 3)

\_\_\_\_\_ TOTAL A + \_\_\_\_\_ TOTAL B = \_\_\_\_\_ 100% TOTAL

7. Has the applicant firm carried claims-made accountants professional liability insurance during the past four (4) years?  Yes  No

If "Yes," provide your insurance history for the last four (4) years below. If "No," please skip to question 10.

Insurance Company	Limits	Deductible	Policy Period	Premium
_____	_____	_____	____/____/____ to ____/____/____	\$ _____
_____	_____	_____	____/____/____ to ____/____/____	\$ _____
_____	_____	_____	____/____/____ to ____/____/____	\$ _____
_____	_____	_____	____/____/____ to ____/____/____	\$ _____

8. What is your current policy's prior acts date? \_\_\_\_/\_\_\_\_/\_\_\_\_

9. Has your firm ever purchased an extended reporting period endorsement or "tail" coverage?  Yes  No

If "Yes", provide term of tail policy \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

10. Provide total gross revenues as indicated in your last filed tax return. \$\_\_\_\_\_

Do not include direct recovery of expenses.

If newly established, provide estimate of expected gross revenues for the current year. \$\_\_\_\_\_

11. Has your firm or any past or present owner, partner, corporate officer or employee upon inquiry:

a. Had any professional liability claims or suits brought against them within the past five years?  Yes  No

b. Been made aware of any circumstance that may result in a claim or suit?  Yes  No

If "Yes" to 11a or b, complete the Supplemental Claim Information below. Coverage cannot be bound until your application is reviewed and approved by an underwriter.

12. Has your firm or any past or present owner, corporate officer or employee upon inquiry:

a. Had a professional liability application denied, policy canceled or policy not renewed?  Yes  No

b. Ever been reprimanded or subject to any fine or criminal penalty related to professional services?  Yes  No

If "Yes" to 12a or b, please provide full details on a separate sheet. Coverage cannot be bound until your application is reviewed and approved by an underwriter.

\*\*\*\*\* PLEASE FORWARD A COPY OF ALL LETTERHEAD USED BY YOUR FIRM. \*\*\*\*\*

**SUPPLEMENTAL CLAIM/INCIDENT INFORMATION**

Indicate whether:  Claim/Suit  Incident

Full name of claimant \_\_\_\_\_

Additional defendants \_\_\_\_\_

Date of alleged error \_\_\_\_/\_\_\_\_/\_\_\_\_

Date became aware of alleged error \_\_\_\_/\_\_\_\_/\_\_\_\_

Date reported \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Insurance Carrier reported to \_\_\_\_\_

If CLOSED, indicate date closed \_\_\_\_/\_\_\_\_/\_\_\_\_ Total amount paid \$\_\_\_\_\_

Of the total amount paid, how much was paid for legal expenses \$\_\_\_\_\_

If PENDING, please forward suit papers or answer all questions below:

Claimant's settlement demand \$\_\_\_\_\_ Defendant's offer for settlement \$\_\_\_\_\_

Insurer's loss reserve \$\_\_\_\_\_

Is claim in suit?  Yes  No If "Yes", amount asked in summons \$\_\_\_\_\_

Limits of Liability \$\_\_\_\_\_ Deductible \$\_\_\_\_\_

Was an engagement letter used?  Yes  No

On your letterhead, please attach a brief description of the claim indicating the alleged error, type of engagement and alleged injury.

**ABC PREMIUM CALCULATION INSTRUCTIONS**

1. Determine the number of years your firm has continuously held claims-made accountants professional liability insurance. **Number of years** \_\_\_\_\_
2. Determine the limit option you wish to purchase. **Limit option** \_\_\_\_\_
3. Circle the corresponding rate per accountant from the chart below. **Rate per accountant \$** \_\_\_\_\_

**LIMIT OPTIONS/RATE PER ACCOUNTANT\***

# of Years of Continuous Insurance	\$100,000/\$200,000	\$250,000/\$500,000	\$500,000/\$500,000	\$1,000,000/\$1,000,000
(o) prior insurance	\$336	\$453	\$504	\$604
(1) year prior insurance	\$504	\$680	\$755	\$906
(2) years prior insurance	\$631	\$852	\$946	\$1,135
(3) years prior insurance	\$755	\$1,019	\$1,133	\$1,359
(4) years or more prior insurance	\$805	\$1,088	\$1,208	\$1,449

\* The above rates include the following states: **CALIFORNIA**

4. Multiply the number of accounting professionals in your firm by the rate identified in #3 to arrive at your total premium due.  
**# of Accounting Professionals** \_\_\_\_\_ **x rate** \_\_\_\_\_ = \$ \_\_\_\_\_ **Total Premium Due**  
*(including coverage for review services)*

- a. If you do not desire coverage for review services the premium is discounted by 10%.

**Total Premium Due in #4 \$** \_\_\_\_\_ **x .90 = \$** \_\_\_\_\_ **Total Premium Due**  
*(without coverage for review services)*

- b. Premium for sole practitioners who are part-time accountants with other full time employment who do not require coverage for review services is discounted by 40%.

**Total Premium Due in #4 \$** \_\_\_\_\_ **x .60 = \$** \_\_\_\_\_ **Total Premium Due**  
*(for part time accountants without coverage for review services)*

**PAYMENT OPTIONS**

- Financing is available with down payment of 25% (minimum premium of \$1,000)

- Mastercard  Visa

Charge card number: \_\_\_\_\_ Expiration date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name on card: \_\_\_\_\_ Phone # \_\_\_\_\_

Billing Address: \_\_\_\_\_

- Check or money order for total premium (made payable to Herbert H. Landy Insurance Agency, Inc.)

The ABC Program has been organized as a Purchasing Group located and domiciled in Illinois, pursuant to legislation enacted by Congress known as the Federal Risk Retention Act of 1986. You will automatically become a member of the purchasing group once your completed application has been approved and your premium payment has been received. This form must be signed/dated by a principal of the firm and submitted along with the attached application. The application and rating page will become part of your Accountants Professional Liability Policy. I declare that the information submitted herein is true and accurate to the best of my knowledge. I understand that an incorrect or incomplete statement could void my protection.

By purchasing this coverage I acknowledge on behalf of the Insured/Applicant that I may be switching from a policy that may contain broader coverage, to a claims-made policy with more restrictive coverage. I have reviewed the attached specimen policy. I fully understand and acknowledge that I am voluntarily choosing to reduce our coverage by waiving the broader liability provisions of our previous policy. I further acknowledge that if I elect the option under items 4a or 4b, coverage will not be provided for claims arising out of review services that were rendered at anytime.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

*Must be signed by principal of firm*

