

# Value Plan

## Application

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.

### Complete this application to qualify for savings.

If you can respond "True" to all of the eligibility statements below, you qualify for the CPA Value Plan.

If you are unable to respond "True" or if you are a CPA professional or firm seeking coverage for services as a registered representative or insurance agent, please call your local representative or Aon Insurance Services at **1-800-221-3023** to receive a Premier Plan application for specialized coverage.

### Eligibility

- A member of my firm is a licensed CPA .....  True  False
- My firm's professional staff is 3 or fewer .....  True  False
- My firm's gross annual revenues were less than \$400,000 in the last fiscal year .....  True  False
- Firm owners or employees do not receive commissions for the referral, solicitation for sale, or sale of securities, insurance products or investments .....  True  False
- Less than 51% of my firm's revenues are derived from Audit engagements .....  True  False
- Less than 51% of my firm's revenues are derived from Management Advisory Services .....  True  False
- Firm owners or employees do NOT have discretionary authority to invest client funds .....  True  False
- 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:

- My firm has NOT audited any publicly held clients .....  True  False
- My firm has NOT prepared financial statements that have been used in any Securities Offerings whether public, private, registered or unregistered .....  True  False
- 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
- 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
- No firm owner or employee is aware of any event, act, omission, dispute or circumstance that is or reasonably could be the basis for a claim .....  True  False
- 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 the 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 Name: \_\_\_\_\_ Date Firm Established: \_\_\_\_\_  
Address: \_\_\_\_\_ Desired Effective Date: \_\_\_\_\_  
City: \_\_\_\_\_ Check  here to receive your quote via fax.  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mr.   
Person to Contact: Ms.  \_\_\_\_\_ Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_  
Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

Please e-mail future policy correspondence to: \_\_\_\_\_ (e-mail address)

- Yes, I would like to receive the free AICPA Insurance Programs E-Newsletter. The E-Newsletter offers Risk Management alerts, new information on products and program sponsored CPA events. My e-mail address is noted above.



Please complete reverse side

Staff size: Professional \_\_\_\_\_ Clerical \_\_\_\_\_

Gross Annual Revenues: Last fiscal year \$ \_\_\_\_\_ Estimated current fiscal year \$ \_\_\_\_\_

Areas of Practice: **Total of all items must equal 100%**

Tax _____%	Management Advisory Services _____%
PFPI/Investment Advisory Services _____%	Information Technology _____%
Bookkeeping/Compilation _____%	General Business Planning _____%
Review _____%	Litigation Consulting _____%
Audit of Non-public Clients _____%	Other Assurance Services _____%

Does your firm use engagement letters on the majority of engagements? . . . . .  Yes  No

Within the past 3 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

Has a member of your firm attended an AICPA Professional Liability Insurance Program Risk Management Seminar in the last three years? . . . . .  Yes  No

**If "Yes," most recent attendance** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Year

Is at least one member of your firm an active member of one of the following professional associations?

AICPA  State CPA Society  Other \_\_\_\_\_

Does the firm belong to the PCPS section of the AICPA? . . . . .  Yes  No

Has your firm been claim free for the past five years? . . . . .  Yes  No

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.**

**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)**  \$5,000  \$1,000  \$0

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 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. ©2005

CNA is a service mark registered with the U.S. Patent and Trademark Office.