



Name of Insurance Company to which Application is made

**MISSOURI
ACCOUNTANTS PROFESSIONAL LIABILITY APPLICATION**

This is an application for a CLAIMS-MADE AND REPORTED Policy

If a policy is issued this application will attach to and become part of the policy, therefore, it is important that all questions are answered accurately. **If additional space is required, please provide complete details on Applicant's letterhead.**

GENERAL INFORMATION

1. Full Legal Name of Applicant (include trading names and DBA's under which the applicant operates):

Principal Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Website Address: _____ Email Address: _____ Contact Name: _____

2. Does the Applicant or any of its owners, officers or partners provide any services under a separate entity name? Yes No
If "Yes", please complete the Separate Entity Supplement for each entity.

3. Does the Applicant have any other office locations? Yes No
If "Yes", please provide complete address(es) on a separate sheet.

4. Applicant is a: Sole Proprietor Partnership Corporation LLC LLP
 Independent Contractor Other: _____

5. Date Applicant established: ____/____/____
(Month/Day/Year)

6. Is the Applicant engaged in the full-time practice of accountancy? Yes No

7. During the past five (5) years, has the name or ownership of the Applicant changed or has there been an acquisition, merger, consolidation or any other change? Yes No
If "Yes", please provide complete details on a separate sheet.

8. Does the Applicant anticipate any material changes to the firm or its practice within the next twelve (12) months? Yes No
If "Yes", please provide complete details on a separate sheet.

9. Complete the following for each principal, partner, officer or director (*attach additional sheet if necessary*):

Name	Title	Years of Experience	Professional Membership or Association
(1)			
(2)			
(3)			

10. a. Indicate the number of staff associated with the Applicant:

Staff: Include Individuals only once	CPAs	Non-CPAs	Total
Owners, Officers, Partners			
Accounting or Tax Professionals			
Consulting Professional			
Support Staff			

b. During the past three (3) years, has the size of staff associated with the Applicant changed by \pm 25%? Yes No
If "Yes", please provide complete details on a separate sheet.

11. a. Indicate gross annual revenue for the Applicant. *(If Applicant is newly established, please provide best estimate)*

Current Fiscal Year (Estimated)	Last Fiscal Year	Second Last Fiscal Year
Ending: / /	Ending: / /	Ending: / /
\$	\$	\$

b. Indicate total number of clients for the last fiscal year: _____

12. Does any client represent more than 25% of the Applicant's gross annual revenue? Yes No
If "Yes", please complete the following:

Name of Client	Industry	Description of Services Provided	% of Income

AREA OF PRACTICE

13. Based on the Applicant's gross revenue for the last fiscal year, indicate the percentage of revenue derived from the following areas of practice. **The total must equal 100%.** *(If newly established, please provide best estimate).*

Area of Practice	%	Engagement Letters Used?	Area of Practice	%	Engagement Letters Used?
Audit: Publicly Held ⁽¹⁾		<input type="checkbox"/> Yes <input type="checkbox"/> No	Information Technology ⁽⁴⁾		<input type="checkbox"/> Yes <input type="checkbox"/> No
Audit: Non-Public ⁽²⁾		<input type="checkbox"/> Yes <input type="checkbox"/> No	Business Valuations		<input type="checkbox"/> Yes <input type="checkbox"/> No
Taxation: Individual		<input type="checkbox"/> Yes <input type="checkbox"/> No	Forecasts & Projections		<input type="checkbox"/> Yes <input type="checkbox"/> No
Taxation: Business		<input type="checkbox"/> Yes <input type="checkbox"/> No	Litigation Consulting		<input type="checkbox"/> Yes <input type="checkbox"/> No
Taxation: Estate		<input type="checkbox"/> Yes <input type="checkbox"/> No	Management Advisory Services ⁽⁵⁾		<input type="checkbox"/> Yes <input type="checkbox"/> No
Bookkeeping		<input type="checkbox"/> Yes <input type="checkbox"/> No	Executor/Trustee Services		<input type="checkbox"/> Yes <input type="checkbox"/> No
Compilations		<input type="checkbox"/> Yes <input type="checkbox"/> No	ERISA/Pension Plans		<input type="checkbox"/> Yes <input type="checkbox"/> No
Review		<input type="checkbox"/> Yes <input type="checkbox"/> No	Securities Activities ⁽¹⁾		<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Financial Planning & Investment Advisory Services ⁽³⁾		<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Services ⁽⁵⁾		<input type="checkbox"/> Yes <input type="checkbox"/> No
			TOTAL:	100%	

- (1) Complete the Securities Supplement.** **(3) Complete the Financial Planning/Investment Advisory Services Supplement.**
(2) Complete the Non-Public Audit Supplement. **(4) Complete the Information Technology Supplement.**
(5) Provide complete description of services on a separate sheet.

14. During the past five (5) years, has the Applicant or any predecessor firm:
a. Provided services to any publicly held client? Yes No
b. Provided professional accounting services, or consented to the use of the Applicant's work product in connection with the issue of public or private offerings or the registration or sale of securities, real estate or other investments? Yes No
If "Yes" to any part of Question 14 above, please complete the Securities Supplement.

15. During the past (5) years, has the Applicant:
a. Received commissions, fees, reciprocity or revenue for referrals, sale or promotion of investments or tax shelters? Yes No
b. Organized, arranged, procured or evaluated investments, real estate or tax shelters or prepared projections for use in these areas? Yes No
c. Participated in the management of any investment partnership, limited partnership, tax shelter or other investment venture? Yes No
d. Received loans from any client? Yes No
e. Made recommendations as to the sale or purchase of any investments, including specific stocks, bonds or other securities for which the firm received compensation? Yes No
If "Yes" to any part of Question 15, please provide complete details on a separate sheet.

16. During the past five (5) years, has the Applicant or any of its professional staff exercised any discretionary control over a client's funds, other than as a trustee? Yes No
If "Yes", please complete the Client Funds Supplement (Non-Trustee).
17. During the past five (5) years, has the Applicant provided audit, attest or review services for a client that subsequently declared or filed bankruptcy, defaulted on a debt obligation or became insolvent? Yes No
If "Yes", please provide complete details including the name of client, services rendered, date of services, date of bankruptcy, default or insolvency, and whether there was a "going concern" reference.
18. During the past five (5) years, has the Applicant or any of its professional staff provided professional accounting services to or served as a fiduciary, committee member, officer, director, partner, employee, principal shareholder or member of any Financial Institution? Yes No
If "Yes", please complete the Financial Institutions Supplement.
19. During the past five (5) years, has the Applicant or any of its professional staff served as a trustee, administrator, or executor? Yes No
If "Yes", please complete the Trustee Supplement.
20. Does any of the Applicant's professional staff maintain a professional license other than for accountancy? Yes No
If "Yes", please indicate name of individual, type of license, description of services provided, name of separate professional liability carrier and limits of liability, if applicable.

INTERNAL CONTROLS AND PROCEDURES

21. Does the Applicant have written internal quality control procedures in place? Yes No
22. Does the Applicant have a formalized training program in place for all new professionals? Yes No
23. During the past two (2) years, indicate the percentage of professional staff:
 a. Who have completed continuing professional education (CPE) courses: _____%
 b. Who participated in a formal loss control program/seminar: _____%
24. Does the Applicant have procedures in place that include the regular use of a conflict of interest avoidance system when accepting new clients? Yes No
If "Yes", indicate the method used: Personal Memory Computer Index File Conflict Committee
 Client Lists Other (describe): _____
25. During the past five (5) years, has the Applicant provided professional accounting services to any client in which any of the Applicant's professional staff (including their spouse) owed an equity interest or served as a director, owner, officer, partner or employee of such client? Yes No
If "Yes", please complete the Outside Interest Supplement.
26. Does the Applicant require the use of engagement letters including fee arrangements on all new matters undertaken? Yes No
If "No," please explain how misunderstandings about the scope and cost of services are prevented.
27. Are declination or non-engagement letters issued on all matters declined by the Applicant? Yes No
If "No", please explain how misunderstandings about representation are prevented.
28. Does the Applicant require the completion of a second person or partner review for any services provided? Yes No
If "Yes," check all that apply: All Services Attest Services Tax Services Other: _____
29. Within the past three (3) years, has the Applicant undergone a peer or quality review? Yes No
If "Yes", indicate: a. Unqualified/Unmodified Qualified/Modified*
 b. Date of Issue: _____
***If the results of the review were qualified/modified, please attach a copy of the peer review report, letter of comments and the Applicant's letter of response.**
30. During the past five (5) years, has the Applicant or any predecessor firm sued (including small claims court) to collect fees? Yes No
If "Yes", please provide complete details including the name of client, services rendered, dates of services, fee amounts, date of suit, current status and whether an engagement letter was used.

INSURANCE COVERAGE HISTORY

31. List the professional liability insurance coverage carried by the Applicant and any predecessor firm(s) during the past five (5) years, including any periods without coverage. **If no past coverage, indicate NONE.**

Effective (mm/dd/yy)	Expiration (mm/dd/yy)	Insurance Company	Limits of Liability (per claim/aggregate)	Deductible/ Retention	Annual Premium
__/__/__	__/__/__				
__/__/__	__/__/__				
__/__/__	__/__/__				
__/__/__	__/__/__				
__/__/__	__/__/__				

32. Does the Applicant's current policy contain a prior acts limitation/retroactive date or provide full prior acts? Yes No
If "Yes", please indicate: prior acts limitation/retroactive date: ____/____/____ or full prior acts coverage.
Please attach a copy of the applicable endorsement. (month/day/year)

33. Does the Applicant's current policy have any endorsements or exclusions or coverage limitations tailored specifically to the Applicant? Yes No
If "Yes", please provide description on a separate sheet and attach a copy of the endorsement(s).

34. Has the Applicant or any predecessor firm(s) ever purchased an extended reporting period endorsement? Yes No
If "Yes", please provide complete details on a separate sheet.

CLAIM/INCIDENT INFORMATION

35. During the past five (5) years, has any professional liability claim or suit ever been made against the Applicant, any predecessor firm or any of the Applicant's current or former professional staff? Yes No
If "Yes", please indicate how many _____ and complete a separate Supplemental Claim Form for each claim.

36. Does any of the Applicant's professional staff know of any incident, negligent act, error or omission or other circumstance that could result in a claim or suit against the Applicant or any predecessor firm or any of the Applicant's current or former professional staff? Yes No
If "Yes", please indicate how many _____ and complete a separate Supplemental Claim Form for each claim.

37. Has the Applicant, any predecessor firm or any of the Applicant's professional staff ever had their license revoked or suspended; or been the subject of a complaint or disciplinary action by any state board of accountancy, any national or state accounting society, any state or federal regulators or any other governmental agency or court; or ever been the charged, indicted, plead guilty or convicted of any felony charge? Yes No
If "Yes", please provide complete details on a separate sheet.

COVERAGE SELECTION

38. Limits of Liability requested (each claim/annual aggregate):

<input type="checkbox"/> \$100,000/\$100,000	<input type="checkbox"/> \$500,000/\$500,000	<input type="checkbox"/> \$1,000,000/\$2,000,000
<input type="checkbox"/> \$100,000/\$300,000	<input type="checkbox"/> \$500,000/\$1,000,000	<input type="checkbox"/> \$2,000,000/\$2,000,000
<input type="checkbox"/> \$250,000/\$250,000	<input type="checkbox"/> \$1,000,000/\$1,000,000	<input type="checkbox"/> \$2,000,000/\$4,000,000
<input type="checkbox"/> \$250,000/\$500,000	<input type="checkbox"/> \$1,000,000/\$2,000,000	<input type="checkbox"/> \$Other: _____

39. Deductible Amount requested (each claim):

<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$20,000
<input type="checkbox"/> \$25,000	<input type="checkbox"/> Other: \$_____				

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE. APPLICATION MUST BE SIGNED AND DATED BY AN OWNER, PARTNER OR OFFICER OF THE APPLICANT.

Signature: _____ Title: _____
 Print Name: _____ Date: _____

PLEASE SUBMIT THIS APPLICATION TO:
(Insert name & address)