

Application Instructions

Thank you for choosing to complete a Professional Liability Insurance application. Please follow the instructions below:

1. Save the PDF application to your computer or device
2. Complete the application using the fillable fields and save the completed document to your computer or device.
3. Submit the completed application on our website:
<https://www.ezinssolutions.com/submitapplication>
4. Our team will review your application and follow up within 2 business days.

If you have any questions, please call one of our representatives at 1-866-225-8464, Monday thru Friday between 8:30 A.M. and 6:00 P.M. EST.



Financial Services Professionals
Application for Professional Liability Insurance

Customer No. _____

NOTICE: THIS IS A CLAIMS-MADE POLICY. PLEASE READ YOUR POLICY CAREFULLY.

This is an application for claims-made coverage for the following professional services performed for others:

- tax preparer or enrolled agent services, including tax advice
• bookkeeping services
• payroll processing services
• data processing services
• notary public services
• recommending and installing hardware and software including training your client in the use of hardware and software.

†Optional coverage is available for services as a financial planner, registered investment advisor, registered representative and life agent when services are rendered to implement a written financial plan. Coverage is limited to the recommendation, sale, and/or management of the following "Financial Products" and "Insurance Products".

- financial instruments insured by the FDIC;
■ United States treasury securities and savings bonds;
■ bonds issued by U.S. based entities that have a Moody's Investors Service Financial Strength rating of Baa or better;
■ mutual funds registered with the Securities Exchange Commission;
■ equities traded on U.S. or Canadian exchanges issued by an entity able to meet the minimum capitalization and other requirements to maintain listing on the NASDAQ SmallCap Market. This does not include real estate investment trusts;
■ variable life products, variable annuities, fixed annuities, life, health, accident or disability contracts issued by an insurance company that have an A.M. Best Financial Strength rating of B or better.

Your Name []Mr. []Mrs. []Ms. _____

Desired Effective Date ____ / ____ / ____

Firm Name _____

E-mail Address _____

Address _____

Telephone (_____) _____

Fax (_____) _____

City _____ State _____ Zip _____

Qualifying Questions After inquiry of all owners, partners and officers of the firm:

- 1. No firm member or employee is a licensed CPA. True [] False []
2. No firm member or employee is aware of any act, omission or fee dispute which might be expected to be the basis of a claim or suit against the firm, firm personnel, or the firm's predecessors in business. True [] False []
3. a. Within the past 5 years, no firm member or employee has been the subject of any regulatory investigation or inquiry; suspended from practice; or charged, indicted, plead guilty or convicted of any felony charge. True [] False []
b. No firm, its members or employees have had any disclosure events or reportable events on their respective Form U-4, U-5, U-6, or Form ADV or similar document. True [] False []
If false, please provide full details on a separate sheet.
4. Within the past 5 years, the firm has not prepared any financial statements that have been used in any securities offerings whether public, private, registered, or unregistered. True [] False []
5. Within the past 5 years, no firm member or employee has had any professional liability insurance declined, canceled or non-renewed (Not applicable in Missouri). True [] False []
6. Within the past 5 years, the firm, its predecessors in business, and associated owners and employees have had no more than 2 claims including suits, settlements, arbitrations, and mediations. True [] False []
7. Within the past 5 years, the total amount paid or reserved on claims, settlements, and/or arbitrations against the firm, its predecessors in business, and associated owners and employees is no more than \$10,000. True [] False []
8. The firm is not a securities broker/dealer and no firm member or employee is a registered general or limited principal of a securities broker/dealer. True [] False []

If you responded "True" to all statements above, you qualify for the Plan. Please complete the information requested and return it as soon as possible. Once your application is received, we'll send you a quotation. If you do not qualify, you can call Affinity Insurance Services toll-free at 1-866-225-8464 to speak to a representative about coverage options available to you.

1. Does your firm or any owners, partners or officers render services or conduct **any** business activities under a separate entity name? Yes No

If yes, complete *SEPARATE ENTITY SUPPLEMENT* on page 3 for all such entities whether coverage is desired or not.

2. Gross annual revenue for the firm and any separate entities for which you desire coverage. Include any commissions earned individually. If you are newly established, please provide an estimate for a full 12 months of revenues.

Estimate For Current Year	Last Fiscal Year	Second Last Fiscal Year
FYE: / /	FYE: / /	FYE: / /
\$	\$	\$

3. **Areas of Practice:** Provide percentage of gross annual revenue derived from the following areas of practice:
 If any person in your firm or any firm affiliate is a registered representative for a broker or dealer, please provide name of broker/dealer.
 Broker/Dealer: _____ Registered representative's CRD#: _____

Class I	
A. Tax	%
B. Bookkeeping and Payroll Processing	%
C. Compilation	%
D. Data Processing	%
E. Recommending, installing and servicing of hardware and software including training your client in the use of hardware and software	%
Class II*	
F. Preparation of Financial Plans*	%
G. Sale of Securities*	%
H. Sale of Insurance Products*	%
I. Non-discretionary Asset Management*	%
J. Discretionary Asset Management*	%
Class III	
K. Other services (Not covered under this policy) <i>Please describe the types of other services your firm provides</i>	%
Total	100%

*Include only the recommendation, sale and/or management of the "Financial Products" listed on Page 1 of this application.

4. Please indicate the number of personnel for firm:
- Owners, partners, & officers _____
- Other employees rendering professional services for clients _____
- Clerical staff (all others) _____
- Total Firm Personnel** _____

5. Provide the total number of personnel rendering **ONLY Class II Services**: _____

6. Does your firm currently carry professional liability insurance for **Class I** or **Class II Services**? Yes No
- If yes, the following information is required in order for us to prepare a price quote.

	Insurance Carrier	Premium	Policy Period	Limits	Deductible	Prior Acts Date
Class I						
Class II						

7. Coverage selection: **Limits of Liability** (per claim/annual aggregate) **Deductible** (aggregate)
- \$100,000/\$250,000 \$500,000/\$1,000,000 \$500
- \$250,000/\$500,000 \$1,000,000/\$2,000,000 \$1,000
8. Does your firm, firm affiliates or their personnel control or disburse client funds? Yes No
 If yes, Employee Dishonesty Coverage may be available subject to underwriting approval.
- Would you like a quotation for Employee Dishonesty coverage to cover those who are employees of your firm?** Yes No
 If yes, please answer the following questions:
- A. List total amount of client funds your firm and firm affiliates control or disburse annually. \$ _____
- B. Is a countersignature required on all client checks issued by personnel of firm and firm affiliates? Yes No
- C. If no, provide name(s), position(s) and firm ownership interest(s) of persons with check signing authority.

- D. Are all client bank accounts reconciled by someone other than firm personnel authorized to deposit or withdraw therefrom? Yes No
 If no, please explain. _____
- E. Do any personnel of firm or firm affiliates act as a business manager for individual clients? Yes No
- F. If yes, provide the number of such clients. _____
- G. Provide the number of firm and firm affiliate employees who control or disburse funds for the firm, firm affiliates, or clients. _____

SEPARATE ENTITY SUPPLEMENT

As referenced in Question 1.

1. Number of entities under which your firm or its owners, partners or officers conduct business activities: _____
2. Provide the following for each entity: (attach a separate sheet for multiple entities.)
- a. Name of entity and form of entity (subsidiary, DBA, joint venture, LLP, etc.): _____
- b. Date established: _____
- c. Percent of ownership held by your firm and all firm personnel: _____
- d. Total professional staff: _____ Total support staff: _____
- e. Provide a detailed description of the entity's services. _____

- f. Gross Annual Revenue:
- | Estimate For Current Year | Last Fiscal Year |
|---------------------------|------------------------|
| FYE: / / | FYE: / / |
| \$ | \$ |
- g. Does the entity currently have professional liability coverage? Yes No If yes, please provide:
- | Insurance Carrier | Policy Period | Limits | Deductible | Prior Acts Date |
|-------------------|---------------|--------|------------|-----------------|
| | | | | |
- h. Coverage may be available for the above entities by endorsement to your policy subject to underwriting approval.
Would you like coverage for these entities? Yes No
 If yes, please list the entities for which you are seeking coverage:

- i. Have the revenues for these entities been included in Question 2. of this application? Yes No

Please sign and date below

THE COMPLETION OF THIS APPLICATION OR THE ATTACHED SUPPLEMENTS, OR TENDERING OF PREMIUM DOES NOT BIND COVERAGE. THIS APPLICATION IS SUBJECT TO THE UNDERWRITING RULES OF THE INSURANCE COMPANY.

NOTICE

1. Neither the responses to this application nor any attachments thereto constitute a submission of a claim or notice of circumstances, occurrences or potential claims under any existing insurance policy. Nor does any such responses indicate or imply that any claim, act or omission disclosed will be covered by this policy.
2. Applicant's failure to report to its current insurance company any claim made against it during the current policy term, or act, omission or circumstance which Applicant is aware of which may give rise to a claim before the expiration of the current policy may create a lack of coverage.

FRAUD NOTICE - WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 may be subject to civil fines and criminal penalties (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.)

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.

Applicant hereby authorizes the release of claim information to the Company from any current or prior insurer of the Applicant.

Must be signed by a person who has the authority to sign on behalf of and to bind the Applicant, all firms and individuals requesting insurance through this application.

Signature of Applicant	Title	Date

I agree that by adding my name above in the "Signature of Applicant" field and submitting this document that this constitutes an electronic signature which is the legal equivalent of my manual/handwritten signature on this document. I consent to the legally binding terms and conditions of this document. I further agree that my signature on this document is as valid as if I signed the document in writing. I am also confirming that I am authorized to enter into this Agreement.

†The coverage summary is for illustrative purposes only and is not a contract. It is intended to provide a general overview of the policy. Only the policy can provide the actual description of terms, coverages, amounts, conditions and exclusions. A specimen policy is available upon request.

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One or more of the CNA companies provide the products and/or services described. The information is intended to present a general overview for illustrative purposes only. It is not intended to constitute a binding contract. Please remember that only the relevant insurance policy can provide the actual terms, coverages, amounts, conditions and exclusions for an insured. All products and services may not be available in all states. CNA is a service mark registered with the United States Patent and Trademark Office. Copyright © 2024 CNA. All rights reserved.