

ACCOUNTANTS PROFESSIONAL LIABILITY INSURANCE
GREAT AMERICAN INSURANCE COMPANY

**NEW YORK STATE – (Except Counties of New York,
Bronx, Queens, Kings and Richmond)**
EXPRESS APPLICATION



NOTICE: THE INSURANCE COVERAGE FOR WHICH YOU ARE APPLYING IS WRITTEN ON A CLAIMS-MADE POLICY FORM. THE COVERAGE OF THIS POLICY IS LIMITED TO LIABILITY FOR CLAIMS WHICH ARE FIRST MADE DURING THE POLICY PERIOD, OR ANY EXTENDED REPORTING PERIOD. COVERAGE UNDER THE POLICY CEASES UPON TERMINATION OF THE POLICY, EXCEPT FOR AUTOMATIC EXTENDED REPORTING COVERAGE, UNLESS THE INSURED PURCHASES OPTIONAL EXTENDED REPORTING COVERAGE.

THIS POLICY MAY PROVIDE THAT CLAIM EXPENSES, INCLUDING LEGAL DEFENSE, ARE WITHIN AND REDUCE THE LIMIT OF LIABILITY AND ARE TO BE CHARGED AGAINST THE DEDUCTIBLE. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES MAY BE REDUCED BY UP TO 50% BY CLAIM EXPENSES FOR POLICIES WITH A LIMIT OF LIABILITY – EACH CLAIM OF \$500,000 OR GREATER. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES MAY BE EXHAUSTED BY CLAIM EXPENSES FOR POLICIES WITH A LIMIT OF LIABILITY – EACH CLAIM OF \$5,000,000 OR GREATER OR A DEDUCTIBLE OF \$100,000 OR GREATER. FURTHER NOTE THAT CLAIM EXPENSES SHALL BE APPLIED AGAINST THE DEDUCTIBLE BY UP TO 50% OF THE DEDUCTIBLE AMOUNT FOR POLICIES WITH A LIMIT OF LIABILITY – EACH CLAIM OF \$500,000 OR GREATER. CLAIM EXPENSES SHALL BE APPLIED AGAINST THE DEDUCTIBLE BY UP TO 100% OF THE DEDUCTIBLE AMOUNT FOR POLICIES WITH A LIMIT OF LIABILITY – EACH CLAIM OF \$5,000,000 OR GREATER OR A DEDUCTIBLE OF \$100,000 OR GREATER.

THE POLICY PROVIDES NO COVERAGE FOR CLAIMS ARISING OUT OF ACTS OR OMISSIONS IN THE PERFORMANCE OF PROFESSIONAL SERVICES WHICH TOOK PLACE PRIOR TO THE RETROACTIVE DATE.

THE POLICY PROVIDES FOR AUTOMATIC EXTENDED REPORTING PERIOD COVERAGE OF 60 DAYS AND OPTIONAL EXTENDED REPORTING PERIOD COVERAGE OF UP TO 7 YEARS. COVERAGE GAPS MAY ARISE AT THE EXPIRATION OF THE POLICY, AUTOMATIC EXTENDED REPORTING PERIOD OR OPTIONAL EXTENDED REPORTING PERIOD. DURING THE FIRST SEVERAL YEARS OF THE CLAIMS MADE RELATIONSHIP, CLAIMS-MADE RATES ARE COMPARATIVELY LOWER THAN OCCURRENCE RATES, AND THE INSURED CAN EXPECT SUBSTANTIAL ANNUAL PREMIUM INCREASES, INDEPENDENT OF THE OVERALL RATE LEVEL INCREASES, UNTIL THE CLAIMS-MADE RELATIONSHIP REACHES MATURITY.

THE RETROACTIVE DATE MAY NOT BE CHANGED DURING THE TERM OF THE CLAIMS MADE RELATIONSHIP AND ANY EXTENDED REPORTING PERIOD.

PLEASE READ THE POLICY CAREFULLY.

To be eligible for this application you must be able to answer "true" to statements 1-9 below. Please contact our office at 800-336-5422 if you are not eligible for this program or have any questions.

Firm Name: _____ Contact Name: _____

Street Address: _____ (Write separate mailing address in margin, if applicable)

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

Phone#: _____ Fax#: _____

Date Established: ____/____/____ E-Mail Address: _____

☐ In lieu of mailing my policy, you may email my policy to the above address. I agree to receive an electronic copy of my application with my policy.

NEW ACCOUNTS: Desired Effective Date ____/____/____ Retroactive Date ____/____/____ RENEWALS: Expiring Policy # _____

**If you have a policy in force, you will need prior acts coverage. Attach a copy of your current
Declarations page showing the prior acts date.**

If you have coverage for any predecessor firm(s) on your current policy please attach a copy of the endorsement.

Total # of Professionals (CPAs, Public Accountants, Tax Preparers, Consultants, Enrolled Agents and Bookkeepers) _____

Gross Annual Revenue based on the Applicant's fiscal year-end data (new firms provide estimate): \$ _____

Statements 1 through 9 must all be “True” in order to be eligible for this program.

Please contact our office if you are not eligible for this program or need coverage for services not offered under the Express program.

1. The Applicant's combined total gross revenues did not exceed \$1,000,000 over the last three (3) year period.	☐ True ☐ False
2. Within the past 3 years the applicant firm has not sued any clients to collect unpaid client fees.	☐ True ☐ False
3. No member or employee of the applicant firm has discretionary authority to invest or control client funds. <i>(Bill-pay and/or payroll are acceptable and are not considered “discretionary control”).</i>	☐ True ☐ False
4. Audit engagements generate 50% or less of the firm's gross billings, and the firm has not performed any public audit/attest work in the last 5 years.	☐ True ☐ False
5. The applicant firm has not provided any tax advice, counsel or opinion; nor organized, sold or prepared any sales material with respect to tax shelters or other tax advantaged investments or any “reportable transaction” as defined in Treasury Reg. Sec 1.60011-4(b).	☐ True ☐ False
6. For services provided on audit engagements or non-attest services for audit clients, the applicant firm has a procedure requiring that engagement letters are used on new engagements and updated as required if the engagement changes. <i>(If the applicant firm does not perform these services, respond “True”).</i>	☐ True ☐ False
7. In the past 5 years, the applicant firm or any member of the firm has not performed services or consented to the use of its work product in connection with any public or private offerings of securities, real estate or other investments.	☐ True ☐ False
8. No member of the applicant firm has had their license revoked or been subject to any disciplinary action, investigation, inquiry or fine by any licensing board, regulatory agency or professional association within the past 5 years.	☐ True ☐ False
9. The applicant firm or anyone to whom this insurance will apply is not aware of any professional liability claim, or any act, omission or personal injury which might reasonably be expected to be the basis of a claim made against them within the past 5 years.	☐ True ☐ False

STEP 1: CIRCLE/CHECK YOUR DESIRED ACCOUNTANTS POLICY PREMIUM

CLAIM EXPENSES MAY BE APPLIED UP TO 50% OF THE DEDUCTIBLE AND 50% OF THE POLICY LIMITS

TABLE 1: Applies to firms whose combined total gross revenues did not exceed \$ 300,000 over the last three (3) year period.

Deductible	\$500,000 / \$500,000	\$500,000 / \$1,000,000	\$1,000,000 / \$1,000,000	\$1,000,000 / \$2,000,000
\$1,000	\$490	\$515	\$570	\$611
\$2,000	\$480	\$505	\$558	\$599
\$5,000	\$450	\$474	\$524	\$562

TABLE 2: Applies to firms whose combined total gross revenues did not exceed \$1,000,000 over the last three (3) year period.

Deductible	\$500,000 / \$500,000	\$500,000 / \$1,000,000	\$1,000,000 / \$1,000,000	\$1,000,000 / \$2,000,000
\$1,000	\$612	\$644	\$712	\$764
\$2,000	\$600	\$631	\$698	\$749
\$5,000	\$563	\$592	\$655	\$703

STEP 1: TOTAL

☐ **1 Year Policy Term Premium:** \$_____ (enter premium selected above)

STEP 2: COMPLETE THIS SECTION AND CIRCLE/CHECK DESIRED PREMIUM TO ADD CYBER COVERAGE OPTION, OR ENTER \$0 ON PAGE 4 TO REJECT CYBER COVERAGE

Question 10 below must be answered “No” to be eligible for Express Cyber Coverage. You may not select Cyber limits greater than your Accountants Policy Limits.

10. After inquiry, is the applicant, or anyone to whom this Insurance applies, aware of any:
- a. Acts, errors or omissions which you have reason to believe could give rise to a cyber related claim? ☐ YES ☐ NO
- b. Intrusion, malware or other IT security related event in the last five (5) years that resulted in you incurring legal, forensic or other related expenses? ☐ YES ☐ NO

NOTE: IT IS AGREED THAT ANY CLAIM, LOSS OR COSTS ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 10 IS EXCLUDED FROM COVERAGE.

CYBER PREMIUM TABLES

TABLE 1: Applies to firms whose combined total gross revenues did not exceed \$300,000 over the last three (3) year period.

Deductible Loss & Expense	\$100,000/ \$250,000	\$250,000/ \$250,000	\$500,000/ \$500,000
\$1,000	☐ \$375	☐ \$450	☐ \$525

TABLE 2: Applies to firms whose combined total gross revenues did not exceed \$1,000,000 over the last three (3) year period.

Deductible Loss & Expense	\$100,000/ \$250,000	\$250,000/ \$250,000	\$500,000/ \$500,000
\$1,000	☐ \$575	☐ \$675	☐ \$775

Express Cyber Extension Endorsement Includes the Following*:

- Separate Limits, Deductible and Retroactive Date from the Accountants Policy
- Cyber Endorsement Limit Selected above applies to Data Compromises and Claims for Wrongful Acts
- Claims Expenses are within, and reduce the Cyber Endorsement Limits
- Business Impersonation Sublimit – 50% of the Cyber Endorsement Limit
- Fraudulent Funds Transfer Sublimit – 50% of the Cyber Endorsement Limit
- Telecommunication Hacking Sublimit – \$100,000
- Reward Coverage Sublimit – \$25,000
- Waiting Period – 12 Hours for Network Disruption & Reputational Harm

* This is only an overview of the Express Cyber Endorsement. Please review the endorsement for all coverages, terms and provisions.

If you have a current cyber policy, please include a copy of your current Declarations page so we may carry over the prior acts coverage.

STEP 2: TOTAL\$ _____ (enter Cyber premium selected on Page 2 or enter \$0 to Reject Cyber coverage)

STEP 3: CALCULATE YOUR TOTAL AMOUNT DUE AND REMIT WITH YOUR APPLICATION

Add total from Step 1 + Step 2:

STEP 1 TOTAL: \$ _____

+

STEP 2 TOTAL: \$ _____ (or enter \$0 to **REJECT** cyber coverage)

TOTAL AMOUNT DUE \$ _____

Notice to Applicant – Please Read Carefully Before Signing

THE APPLICANT AND FIRM ACCEPTS NOTICE THAT ANY POLICY ISSUED WILL APPLY ON A “CLAIMS-MADE” BASIS. The undersigned is authorized by and acting on behalf of the Applicant and represents that all statements and particulars herein are true, complete and accurate and that there has been no suppression or misstatements of fact and agrees that this application shall be the basis of coverage.

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THE APPLICANT AND FIRM ACCEPTS NOTICE THAT THEY ARE REQUIRED TO PROVIDE WRITTEN NOTIFICATION TO THE COMPANY OF ANY CHANGES TO THIS APPLICATION THAT MAY HAPPEN BETWEEN THE SIGNATURE DATE BELOW AND ANY PROPOSED EFFECTIVE DATE. THE APPLICATION MUST BE SIGNED BY AN ACTIVE OWNER, PARTNER, PRINCIPAL, OFFICER, OR MEMBER OF THE APPLICANT.

NEW YORK FRAUD 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 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 each such violation.

Print Name

Title

Signature

Date

INCOMPLETE, UNSIGNED OR UNDATED APPLICATIONS WILL BE RETURNED FOR COMPLETION.

BROKER NAME:	
AGENCY NAME:	
TAXPAYER ID NO.:	PRODUCER LICENSE NO. AND STATE:
PRODUCER'S ADDRESS (No., Street, City, State, and Zip:)	

To bind coverage please send the completed application, expiring Declarations or proof of retroactive coverage (if new business), and check (including all taxes/surcharges, if applicable) to your agent listed below:



Premium Payment Options

If Applicable Please Enter:

Applicant Name: _____

Policy Number: _____

Account Number: _____

To avoid a gap in your insurance protection we must receive payment by the policy effective date.

☐ **Option 1:** Mail your check for the **Annual Premium (including all applicable state taxes and surcharges)** payable to the **Herbert H. Landy Insurance Agency Inc.**, 100 River Ridge Drive, Suite 301, Norwood, MA 02062.

☐ **Option 2:** Sign and complete this form to authorize **Herbert H. Landy Insurance Agency Inc.** to make a onetime debit to your checking or savings account.

By signing this form you give us permission to debit your account for the amount indicated. . This is permission for a **single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.**

*******Please fax this form to 800-344-5422 or email to payment@landy.com*******

Please complete the information below:

I _____ authorize **Herbert H. Landy Insurance Agency Inc** to charge my bank account

Indicated below for \$ _____ (**Annual Premium or deposit if financing including all applicable state taxes and surcharges**) + **\$25.00 Non-refundable Convenience fee**

Account Type: ☐ Checking ☐ Savings

Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____



SIGNATURE _____

DATE _____

I understand that because this is an electronic transaction, these funds may be withdrawn from my account within a processing window of 1 to 7 business days from the time The Herbert Landy Insurance Agency is in receipt of this signed and dated form . In the case of the payment being rejected for Non Sufficient Funds (NSF) I Agree The **Herbert H. Landy Insurance Agency Inc** may at its discretion attempt to process the charge again, once for an additional **\$25.00** NSF fee. The charge will be initiated as a separate transaction from the authorized payment. If the payment is rejected a second time, Certified funds will be required and will include an additional \$50.00 fee for the two previously rejected transactions. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I will not dispute The **Herbert H. Landy Insurance Agency Inc** billing with my bank so long as the transaction corresponds to the terms indicated in this agreement.

☐ **Option 3:** Premium Financing is provided by Imperial Premium Financing Specialist Inc. An initial minimum down payment of 20% will be required. The balance will be financed over 9 months. If you would like to finance your premium please either mail your check made payable to the Herbert H. Landy Insurance Agency for your down payment or use option #2.

Note: If you are purchasing an Express two year policy; two financing options are available to you:

1. Finance each year individually with a 20% D/P and 9 installments.
2. Finance the full 2 year premium with a 25% D/P and 12 installments.

If you have any questions, or need further assistance please do not hesitate to contact us.

The Herbert H. Landy Insurance Agency Inc.
100 River Ridge Drive | Suite 301 | Norwood, MA 02062
Tel: (800) 336-5422 | Fax: (781) 449-7908
www.landy.com