

**PROFESSIONAL INDEMNITY INSURANCE
CERTIFIED AUDITORS -ACCOUNTANTS
PROPOSAL FORM**

1. GENERAL DATA

Company Name:		
Address:		
Tel:	Fax:	Email:
Tax Nr:	Year Established:	Website:

2. DETAILS OF PRACTICING PRINCIPALS & PARTNERS (attach list with Names and Registry number) /

Full Name	Qualifications – Years of Prof. Experience	Position – Years in Position

Principals, Partners or Officers	
Qualified Auditors-Accountants	
Assistant Auditors –Accountants	
Administration staff	

Total Number of Principals - Partners & Staff :

a) Does the Firm any Partner or Principal manage, own or have financial control of any bank, trust company, mortgage or loan association or real estate company or undertake work as Trustee, Director or Company Secretary? If YES, give details YES NO

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b) Does any Partner, Principal or staff undertake work as Receiver, Liquidator or Trustee in bankruptcy? If YES, give details YES NO

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3. NATURE & VOLUME OF ACTIVITY (% of fees)

PROFESSIONAL ACTIVITY		TYPE OF CLIENT	
Taxation	%	Industry - Commerce	%
Examination of Annual Reports		Financial	%
Audits for quoted Companies	%	Technology	%
Audits for other Companies	%	Construction	%
Share registration	%	Services	%
Insolvencies - liquidations	%	Other (specify):	%
Mergers -Acquisitions	%		100%
Management Consultancy	%		
Other (specify):	%		
	100%		

4. FINANCIAL DATA (€)

Last Year-1	Last Year	Current Year (estimation)

5. PREVIOUS INSURANCE – CLAIMS

 a) Have you previously been insured? YES NO If YES, specify

Insurance Company	Policy period	Indemnity Limit

 b) Have any claims been made during the past 5 years against your firm? YES NO

 c) Is your company aware of any circumstances or incidents that may result in a claim against your company? YES NO

 d) Has any partner or member of staff been involved in any fraud or dishonesty? If YES, pls refer: YES NO

 Where “YES” give details:

5. INDEMNITY REQUIRED

Any one accident€ Annual Aggregate€

 Deductible 5,000€ 10,000€

EXTENSIONS OF COVER

- Cover liability of Incoming & Outgoing Partners
- Loss of Documents
- Do you need Retroactive cover? YES NO If “YES”, specify date: ___/___/___

I declare on behalf of the Firm that the statements in this Proposal are true and that I have not misstated or suppressed any material facts. I agree that this proposal, together with any other information supplied by me, shall form the basis of the contract of insurance effected thereon. I/We undertake to inform the Insurer of any material alteration to these facts occurring before completion of the insurance contract. /

Date: ___ / ___ / ___

Company’s Seal

Signature / Full Name

IMPORTANT NOTICE

- All questions must be answered to enable a quotation to be given
- All information provided is confidential.
- This proposal is for a “Claims made” Insurance Policy.