

NEW HAMPSHIRE INSURANCE COMPANY
Administrative Offices: 175 Water Street 18th Floor, New York, NY 10038



CPA Protector Plan
Claims/Incident Supplemental Application

Florida

If you answered yes to the questions regarding claims or potential claims complete a separate supplement for each actual or potential claim. A form should be completed for any claim, demand, or suit and any incident, circumstance, act, error, omission, Personal Injury or Personal Identity Event that may result in a claim, demand or suit. Answer each question fully, do not leave any blank. If there is not enough space, please attach a separate sheet. Please print or type responses

1. Full name of individual(s) of applicant firm involved in claim:

2. List any additional defendant(s): _____

3. Full name of claimant(s) or potential claimant(s):

4. a. Date of alleged act, error, Personal Injury or Personal Identity Event: _____

b. Date claim/incident was made against applicant firm: _____

5. a. Name of Insurance Company: _____

b. Date reported to company: _____

6. Type: Incident ___ Claim ___ Suit ___ Disciplinary Complaint ___

7. Present Status of claim: Open/incident ___ Closed ___

a. If open/incident provide:

Claimant's settlement demand \$ _____ Defendant's offer for settlement \$ _____

Insurer's reserve \$ _____ Amount paid to date \$ _____

b. If closed provide:

Total damages paid and outstanding (including deductible) \$ _____

Date closed _____

8. Description of the claim or incident:

(Do not respond with "contact Company", "refer to file" or "see attached loss run". Information must be provided to allow an evaluation of the claim or incident.)

a. Allegation upon which claimant bases claim: _____

b. Description of case and events: _____

9. What procedures have been implemented to prevent a similar claim? _____

It is acknowledged and agreed that any claim or other loss arising from a matter disclosed or should have been disclosed in this supplement is excluded from coverage under the proposed insurance, for all Insureds, without limiting any other remedy available to the Company for non-disclosure. All current situations should be reported to your current insurance carrier.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.

The applicant understands the information submitted herein becomes a part of the applicant's application and is subject to the same representations and conditions.

Signature of Authorized Representative of the Firm

Date

Print Name

Title (must be signed by managing partner or managing executive of the Firm)

Attest _____

Producer / Agent: B&B Protector Plans, Inc. (dba Professional Services Plans)

License Number: L006066

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