



CAMICO

**NEW YORK
ACCOUNTANTS
PROFESSIONAL
LIABILITY
INSURANCE POLICY**

SPECIMEN



CAMICO Mutual Insurance Company
Tel: 800.652.1772

ADDITIONAL INCLUDED BENEFITS

In addition to the benefits described in your policy every *Named Insured* automatically qualifies for additional included benefits designed to minimize your professional liability exposure by helping you manage your firm. These additional included benefits are:

- Unlimited use of CAMICO's three hotlines, providing immediate access to professional assistance and advice. This service includes the **Loss Prevention hotline**, providing CPAs and other professionals that can assist you with practice and firm management issues, the **Claims hotline**, providing claim professionals that can assist you with legal liability concerns *before* they become a claim and the **Tax hotline**, providing CPAs and attorneys to assist you with some federal tax issues.
- Unlimited use of CAMICO's **subpoena services**, providing assistance with the receipt of and compliance with most types of subpoena and deposition notices even when there is no Claim. CAMICO will evaluate the need for additional assistance and, where appropriate, attorneys may be provided to assist you at no cost. **Subpoena services** are accessed through the **Claims hotline**.
- Unlimited access to all of CAMICO's risk management tools and documents through the **Members Only section of CAMICO.com**.
- Full participation in all of CAMICO's **CPE events**, including seminars, conferences, in-firm training and web-based training. (Some CPE programs may be limited by geography or firm characteristics.)
- Full participation in CAMICO's **dividend program**. The timing, amount and method of allocating dividends amongst *Insureds* are determined by and at the discretion of the Board of Directors.
- The *Named Insured* has the right to purchase *Optional Extended Reporting Coverage* for a period of up to three years as more fully described in Article V. of the policy. The *Named Insured* may request *Extended Reporting Coverage* for a longer period of time. CAMICO, at its option, may agree to offer such coverage.

CAMICO urges you to take advantage of these additional included benefits so that, together, we can reduce the cost of claims and increase the effectiveness of your firm.

NOTICE

THESE POLICY FORMS AND THE APPLICABLE RATES ARE EXEMPT FROM THE FILING REQUIREMENTS OF THE NEW YORK STATE INSURANCE DEPARTMENT, BUT MEET THE MINIMUM STANDARDS OF THE NEW YORK INSURANCE LAW AND REGULATIONS.

This Policy is written on a CLAIMS-MADE basis. This Policy provides no coverage for *Claims* arising out of incidents, occurrences, or alleged wrongful acts, errors or omissions which took place prior to the *Retroactive Date* stated in the Policy and shown on the Declarations page. This Policy covers only *Claims* actually made against an *Insured* while the Policy remains in effect. All coverage under the Policy ceases upon the termination of the Policy except for the *Automatic Extended Reporting Coverage*, or unless the *Named Insured* purchases *Optional Extended Reporting Coverage* (See, V. *Insured's Right to Extended Reporting Coverage*).

Extended Reporting Coverage provides that *Claims* made against an *Insured* during an *Extended Reporting Coverage Period* will be covered only if the error, omission, or negligent act giving rise to the *Claim* took place prior to the expiration or cancellation date of the Policy and after the *Retroactive Date*. The *Automatic Extended Reporting Coverage Period* is for sixty (60) days after the termination of the Policy. If purchased, the *Optional Extended Reporting Coverage Period* is for a minimum of thirty-six (36) months after the termination of the *Policy Period* and includes the *Automatic Extended Reporting Coverage Period*. Because neither *Extended Reporting Coverage Period* is unlimited, there may be a gap in coverage upon expiration of either *Extended Reporting Coverage Period* if: the *Named Insured* does not buy a policy with “prior acts” coverage to replace this Policy; or, the *Named Insured* purchases a replacement policy with coverage that is not as broad as this Policy; or, the *Named Insured* buys no replacement policy whatsoever. At the end of the applicable *Extended Reporting Coverage Period*, this Policy will not provide coverage for any new *Claim* reported to the Company.

During the first several years of the claims-made relationship, claims-made rates are comparatively lower than occurrence rates, and there will likely be substantial annual premium increases, independent of overall rate level increases, until the claims-made relationship reaches maturity.

Disputes with the Company arising out of this Policy or pertaining to the relationship between the *Insurer* and an *Insured* hereunder are subject to mediation. (See, VI. POLICY CONDITIONS, D. Legal Action Against the Company.)

The Policy contains additional restrictions on coverage. Please review the entire Policy carefully and discuss the coverage thereunder with your insurance agent, broker or other representative.

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ACCOUNTANTS PROFESSIONAL LIABILITY INSURANCE POLICY

In consideration of the *Named Insured's* payment of premium and Deductible(s), and in reliance upon the *Named Insured's* statements made in the original application and all renewal or supplemental applications, all of which are incorporated into this policy by this reference, CAMICO Mutual Insurance Company ("the Company") agrees with the *Named Insured* as follows:

I. INSURING AGREEMENTS

A. Coverage for *Damages* and Reporting Requirements

1. The Company will pay those sums that an *Insured* becomes legally obligated to pay as *Damages* because of a *Claim* arising out of an *Insured's* negligent act, error or omission in rendering or failing to render *Professional Services* performed after the *Retroactive Date* and before the end of the *Policy Period*, provided that:

- (a) the *Claim* was first made against the *Insured* and reported to the Company during the *Policy Period* or any *Extended Reporting Coverage Period* or any subsequent renewal of the policy; and
- (b) the *Claim* does not arise from circumstances which, prior to the effective date of the *Policy Period*, any *Insured* might reasonably expect would be the basis for a *Claim*; and
- (c) the *Claim* was not reported to any professional liability insurer, including the Company, prior to the effective date of the *Policy Period* identified in the policy's Declarations.

An act, error or omission which is continuing in nature shall be deemed to have occurred only on the date on which that act, error or omission began and not on any subsequent date. *Multiple Acts, Errors or Omissions* shall be deemed to have occurred only on the date that the earliest of those acts, errors or omissions began and not on any subsequent date. A *Claim* is deemed made on the date the Company receives notice of the *Claim* from the *Insured* or a third party. When a *Claim* involves *Multiple Acts, Errors or Omissions*, the *Claim* is deemed made on the date the first of the *Multiple Acts, Errors or Omissions* forming the *Claim* is reported to the Company.

2. If an *Insured* first becomes aware of a *Potential Claim* during the *Policy Period* and provides the Company with written notice as described in section VI. POLICY CONDITIONS, A. *Insured's* Duties Upon Notice of *Claim* or *Potential Claim*, paragraph 1., then any *Claim* that may be made later against an *Insured* arising from those acts, errors or omissions will be deemed reported to the Company on the date the Company received the written notice of the *Potential Claim*.

B. Defense and Settlement of *Claims*

1. The Company has the right and duty to defend and settle *Claims* alleging *Damages*, even if the *Claim* is groundless, false or fraudulent. The Company has the right to appoint counsel and to investigate and negotiate settlement of any *Claim*.

2. The Company will not settle any *Claim* without the *Named Insured's* written consent. If the *Named Insured* withholds its consent to any settlement recommended by the Company and elects to contest a *Claim* or continue the legal proceedings, then the Company's liability for that *Claim* will not exceed: (1) the amount of the recommended settlement plus *Claim Expenses* incurred up to the date the *Named Insured* withheld its consent, or (2) the remaining Limit of Liability, whichever is less.

3. The Company will cease defending and/or paying *Claim Expenses* when the applicable Limit of Liability has been exhausted by payment of *Damages* or *Claim Expenses*.

C. Limits of Liability, Sub-Limits and Deductibles

1. Limit of Liability – Per *Claim* and Sub-Limits

The maximum amount payable by the Company for *Damages* and *Claim Expenses* for each covered *Claim* is the Per *Claim* Limit of Liability stated in the Declarations, less the Per *Claim* Deductible, subject to the following sub-limits:

(a) The maximum amount payable by the Company for *Damages* and *Claim Expenses* for each covered *Claim* arising from, related to or in connection with any *Tax Shelter Investment* shall be \$100,000 in excess of the Per *Claim* Deductible.

(b) The maximum amount payable by the Company for *Damages* and *Claim Expenses* for each covered *Claim* arising from, related to or in connection with any *Insured's* misappropriation, misuse, theft or embezzlement of funds shall be \$100,000 in excess of the Per *Claim* Deductible.

A single Per *Claim* Limit of Liability applies to a *Claim* arising from *Multiple Acts, Errors or Omissions*, regardless of the number of claimants, lawsuits, or *Insureds* involved.

2. Limit of Liability – Policy Aggregate and Aggregate Sub-Limits

The maximum amount payable by the Company for *Damages* and *Claim Expenses* for all covered *Claims* made and reported during the *Policy Period* is the Policy Aggregate Limit of Liability stated in the Declarations, less all sums paid for Per *Claim* Deductibles up to the amount of the Policy Aggregate Deductible, if purchased, subject to the following Aggregate sub-limits:

(a) The maximum amount payable by the Company for *Damages* and *Claim Expenses* for all covered *Claims* made during the *Policy Period*, the *Automatic Extended Reporting Coverage Period*, or any *Optional Extended Reporting Coverage Period* arising from, related to or in connection with *Tax Shelter Investments* shall be \$100,000 in excess of the Per *Claim* Deductible.

(b) The maximum amount payable by the Company for *Damages* and *Claim Expenses* for all covered *Claims* made during the *Policy Period*, the *Automatic Extended Reporting Coverage Period*, or any *Optional Extended Reporting Coverage Period* arising from, related to or in connection with misappropriations, misuses, thefts or embezzlements of funds by *Insureds* shall be \$100,000 in excess of the Per *Claim* Deductible.

3. Deductible – Per *Claim*

The *Named Insured* shall pay the Per *Claim* Deductible, in the amount stated on the Declarations for *Claim Expenses* and *Damages* resulting from each *Claim*. The *Named Insured* is responsible for reimbursing the Company for the Deductible.

4. Deductible – Policy Aggregate

When the *Named Insured* has purchased an Aggregate Deductible, the maximum amount of Deductible(s) payable by the *Named Insured* with respect to all covered *Claims* first made against an *Insured*

during the *Policy Period* or the *Automatic Extended Reporting Coverage Period* is the amount of the Policy Aggregate Deductible stated in the Declarations.

5. Expenses for *Potential Claims*

Any expenses incurred by the Company on behalf of an *Insured* prior to a *Claim* being made are not chargeable against the Per *Claim* Deductible or against the applicable Limit of Liability.

6. Reimbursement of the Company

If the Company pays any *Claim Expenses* or *Damages* within the Per *Claim* Deductible or Aggregate Deductible or in excess of the applicable Limit of Liability, the *Named Insured* shall reimburse the Company these amounts within thirty (30) days of the Company's request. All *Insureds* are jointly and severally liable for reimbursement of these amounts to the Company.

7. Transfer of Duties When Limit of Liability is Reached

(a) If the Company concludes that the Per *Claim* or the Aggregate Limit of Liability is likely to be reached upon the payment of judgment(s) or settlement(s) for *Claims* or suits to which this insurance may apply, the Company will provide the *Named Insured* with written notice of the anticipated exhaustion. When the Limit of Liability actually has been reached in the payment of judgment(s) or settlement(s), the Company will provide the *Named Insured* with written notice as soon as practicable of the exhaustion of the Limit of Liability and the termination of the Company's duty to defend. The Company will initiate and cooperate in, the transfer of control, to the *Named Insured*, of all remaining *Claims* and suits seeking *Damages* that were reported to the Company prior to exhaustion of the Limit of Liability and that are subject to the exhausted Limit of Liability. In reliance upon the *Named Insured's* agreement to cooperate in the transfer of control of those *Claims* and suits, the Company agrees to take such steps as it deems appropriate to avoid default in, or to continue defense of, such *Claims* or suits until the transfer is completed. The Company will take no action whatsoever with respect to any *Claim* or suit seeking *Damages* if the *Claim* or suit is reported to the Company after the Policy Aggregate Limit of Liability has been exhausted.

(b) The *Named Insured* and any other *Insured* involved in a *Claim* or suit seeking *Damages* subject to the Policy Aggregate Limit of Liability must arrange for the defense of such *Claims* or suits within such time period as agreed to between the *Named Insured* and the Company, or in the absence of any such agreement, then as soon as practicable. The *Named Insured* will reimburse the Company for expenses the Company incurs in taking those steps the Company deems appropriate in accordance with this paragraph. The duty to reimburse the Company will begin on the date on which the applicable Limit of Liability is reached, or the date on which the Company sent notice, whichever is later.

(c) The exhaustion of the applicable Limit of Liability by the payment of judgment(s) or settlement(s), and the termination of the Company's duty to defend, will not be affected by the Company's failure to notify the *Named Insured* of these provisions.

D. Supplementary Policy Benefits

1. Regulatory and/or Disciplinary Proceedings

The Company will defend an *Insured* at regulatory proceedings and/or at disciplinary hearings before any entity responsible for regulating the practice of accountancy. The maximum amount payable by the Company pursuant to this paragraph for all attorney fees and costs incurred is \$5,000 per *Policy Period*.

Amounts paid on behalf of an *Insured* pursuant to this paragraph are not chargeable against the Deductible or the Limits of Liability.

The Company will not indemnify any *Insured* for any monetary assessment or penalty that may be levied against any *Insured* as a result of any regulatory proceedings and/or disciplinary hearings.

2. Deductible Reduction

The Company will reduce the *Named Insured's* applicable Per *Claim* Deductible by fifty percent (50%), up to a maximum of \$50,000, under the following circumstances: (a) when any *Insured* reports a *Potential Claim* to the Company prior to the *Claim* being made against the *Insured*; or (b) when the *Named Insured* uses formal mediation to seek a resolution of a *Claim*.

However, no reduction in the Per *Claim* Deductible will be available for either: (a) any *Claim* arising from, related to or in connection with any *Tax Shelter Investment*, or (b) any *Claim* arising from, related to or in connection with any *Insured's* misappropriation, misuse, theft or embezzlement of funds.

3. Per Diem Reimbursement

The Company will pay \$300 per day to the *Named Insured*, up to a maximum payment of \$6,000 per *Claim*, to compensate an *Insured* for attendance at mediation, arbitration or trial proceedings at the Company's request.

E. Policy Territory

This insurance applies to *Claims* made anywhere in the world.

II. WHO IS AN INSURED

Each of the following *Persons* is an *Insured*, but only while performing *Professional Services* for the benefit of the *Named Insured* or a *Predecessor Firm* on or after the *Retroactive Date*:

- (a) The *Named Insured* identified in the Declarations or in an endorsement.
- (b) A current or former owner, partner, shareholder or employee of a *Named Insured*.
- (c) Any *Person* who, during the *Policy Period*, becomes an owner, partner, shareholder or employee of a *Named Insured*.
- (d) Temporary staff or a contract employee of a *Named Insured*, but only for *Professional Services* performed on behalf of and under the direct supervision of a *Named Insured*.
- (e) A *Predecessor Firm*.
- (f) A *Person* acquired by or merged with a *Named Insured* during the *Policy Period*, but only for *Professional Services* provided after the acquisition or merger.
- (g) The legal representative of an *Insured*, but only to the extent of that *Insured's* rights and duties under this policy.

III. EXCLUSIONS

This policy does not apply to:

- (a) **Intentional Misconduct:** Any *Claim* based on or arising out of a dishonest, fraudulent, malicious or criminal act, error or omission of any *Insured*. The Company will defend but not indemnify an *Insured* with respect to: (i) any *Claim* alleging an *Insured* participated in, aided or abetted in a civil conspiracy, and (ii) any *Claim* alleging an *Insured* has violated any state or federal statutes prohibiting financial elder abuse.
- (b) **Bodily Injury/Property Damage:** Any *Claim* based on or arising from *Bodily Injury* or *Property Damage*, but this exclusion shall not apply to any *Claim* seeking *Damages* for humiliation or emotional distress based upon allegations of *Defamation*.
- (c) **Claims By An Insured:** Any *Claim* made by an *Insured* or a *Related Individual* against an *Insured*.
- (d) **Insured Acting In Another Capacity:** Any *Claim* in connection with or arising out of the service of any *Person*, who is an *Insured*, acting as an employee, officer or director of any company, business, entity or charitable organization other than the *Named Insured*.
- (e) **Employment Practices Liability:** Any *Claim* in connection with or arising out of any *Insured's* employment obligations, decisions, practices or policies as an employer, including, but not limited to, acts of discrimination, humiliation or harassment and acts in violation of the Americans with Disabilities Act.
- (f) **Other Business Entities:** Any *Claim*, whether or not related to *Professional Services*, made by, in the right of, against, in connection with or arising out of any entity not named in the Declarations in which:
 - 1. any *Person* who is an *Insured* (or an *Affiliate* or *Related Individual* of that *Person*) is or was at any time managing, controlling or operating the entity; or
 - 2. the aggregate ownership of all *Persons* who are *Insureds* (including *Affiliates* and *Related Individuals* of such *Persons*) at any one time was or is more than twenty percent (20%).
- (g) **Claims Seeking Return of Insured's Fees:** That part of any *Claim* seeking the return of or reimbursement of fees for *Professional Services*.
- (h) **Punitive or Exemplary Damages:** Indemnity of any punitive or exemplary damages, fines, sanctions, penalties or multiplied damages (whether doubled, trebled or otherwise), unless required by law.
- (i) **Claims Following Insured's Suit For Fees:** Any *Claim* made by any *Person* or entity after an *Insured* has sued such *Person* or (*Affiliate* of such *Person*) to obtain payment of fees for *Professional Services*, unless that *Insured* has consulted with the Company prior to filing the suit. If the *Insured* fails to consult with the Company prior to filing the suit, then the *Named Insured* agrees to pay fifty percent (50%) of the first \$50,000 in *Claim Expenses* and/or *Damages* incurred with respect to such *Claim*. This fifty percent (50%) co-pay obligation: (1) is separate from and in addition to the *Named Insured's* obligation to pay the applicable Deductible pursuant to section I. INSURING AGREEMENTS, C. Limits of Liability, Sub-Limits and Deductibles, and/or (2) precedes and is separate from the terms of any endorsement modifying provisions regarding payment of *Claim Expenses* from within the applicable Limits of Liability and from the terms of any endorsement providing a Separate Defense Limit. This exclusion does not eliminate coverage for, and the fifty percent (50%) co-pay obligation is not triggered by, any *Claim* made after an *Insured's* use of arbitration to resolve a fee dispute with the *Person* making the *Claim*.
- (j) **Products Liability:** Any *Claim* in connection with or arising out of the use of, or existence of any condition in or a warranty of, products sold or distributed by an *Insured*.

IV. DEFINITIONS

Wherever used in this policy, the words or phrases in *italics* have special meanings:

- (a) An *Affiliate* of a specified *Person* means a *Person* that directly, or indirectly through one or more intermediaries, controls or is controlled by or is under common control with the *Person* specified.
- (b) *Bodily Injury* means bodily injury, sickness, disease, mental illness, emotional distress or humiliation sustained by a natural person, including death resulting from any of these at any time.
- (c) A *Claim* means a demand received by any *Insured* for money or services, and includes the service of suit(s), a request that an *Insured* agree to waive a legal right or sign an agreement to toll a statute of limitations, or a demand for arbitration. A *Claim* also includes two or more *Claims* arising out of or resulting from a single act, error or omission in rendering *Professional Services*, or from *Multiple Acts, Errors or Omissions* in rendering *Professional Services*, whether such demands are made: (1) against one or more *Insureds*, (2) by one or more *Persons*, or (3) during one or more *Policy Periods*.
- (d) *Claim Expenses* are the fees charged by an attorney designated by the Company to defend any *Insured*, and all other fees, costs and expenses resulting from the investigation, adjustment, defense and appeal of a *Claim*, if incurred by the Company or by an *Insured* at the Company's request. *Claim Expenses* do not include: (1) salaries of the Company's employees or independent adjusters, or (2) any fees, costs or expenses incurred by an *Insured* without the Company's consent.
- (e) *Damages* means a monetary judgment or award, or sums paid in settlement, but does not include: (1) any fine, sanction, penalty, punitive or exemplary damages, or multiplied damages (whether doubled, trebled or otherwise); (2) reimbursement of any *Insured's* fees for *Professional Services*; or (3) *Claim Expenses*.
- (f) *Defamation* means the publication or utterance of a libel or slander or other defamatory or disparaging material or a publication or utterance in violation of an individual's right of privacy.
- (g) *Extended Reporting Coverage* provides a period of time after the end of the *Policy Period* for reporting a *Claim* arising out of any negligent acts, errors or omissions occurring prior to the end of the *Policy Period* and otherwise covered by this Policy. *Extended Reporting Coverage* is offered by the Company under the terms and conditions stated in section V. *Insured's Right To Extended Reporting Coverage* of this Policy and the *Extended Reporting Coverage* endorsement issued by the Company. This Policy provides *Automatic Extended Reporting Coverage* for a period of sixty (60) days from the cancellation date, and the *Named Insured* may be offered the option to purchase *Optional Extended Reporting Coverage*.
- (h) An *Insured* means the *Named Insured* and any *Person* who qualifies as an *Insured* under section II. Who Is An *Insured*.
- (i) *Multiple Acts, Errors or Omissions* means all acts, errors or omissions in rendering *Professional Services* that are logically or causally connected by any common fact(s), circumstances, situation, transaction(s), event(s), advice or decision(s).
- (j) The *Named Insured* is the *Person* identified on the Declarations attached to this policy.
- (k) A *Person* means any natural person or legal entity.
- (l) The *Policy Period* is the period of time which begins on the effective date stated on the Declarations and ends on the renewal, termination, expiration or cancellation of this Policy, and specifically excludes any *Extended Reporting Coverage*.

(m) A *Potential Claim* is an event or circumstances that any *Insured* might reasonably expect would be the basis for a *Claim*.

(n) *Predecessor Firm* is: (i) any firm, some or all of whose partners or shareholders have joined the *Named Insured*, provided such partners or shareholders produced over fifty percent (50%) of the prior firm's annual gross billings and such billings have been assigned to the *Named Insured*, or (ii) any sole proprietor who joined the *Named Insured* and who has assigned over fifty percent (50%) of the billings from the former sole proprietorship to the *Named Insured*.

(o) *Professional Services* are any professional services performed by an *Insured* as long as the fees or commissions, if any, or other benefits from such services inures to the benefit of the *Named Insured*. *Professional Services* also includes any *Insured's* services as a member of a formal accreditation, standards review, or other similar professional board or committee that is related to the accounting profession, including services ordinarily performed or advice given in connection with programs sponsored by the American Institute of Certified Public Accountants or any state society of Certified Public Accountants.

(p) *Property Damage* means physical injury to, conversion of, or destruction of tangible property, including the loss of use of tangible property.

(q) *Related Individual* means the spouse, children, parents, and/or grandparents of any *Insured*, and any trust or estate of which any of them is a beneficiary.

(r) The *Retroactive Date*, stated in the Declarations, is the earliest date from which this Policy provides coverage for *Professional Services*.

(s) *Tax Shelter Investment* means:

1. (i) a Treasury Regulation §1.6011-4(b)(2) "reportable transaction"; **OR**
(ii) any investment or other arrangement where (a) the investment or other arrangement actually generates or (b) representations made as part of the investment or other arrangement's written sale offering indicate that the investment or arrangement will generate taxable income exclusions, tax deductions, or tax credits exceeding the investment or other arrangement's required capital contribution by at least two to one (2:1); **OR**
(iii) any other investment, plan or arrangement having tax avoidance or evasion as its primary purpose. An investment, plan or arrangement will have a primary tax avoidance or evasion purpose when that purpose exceeds any other purpose of the investment, plan or arrangement;

AND

2. Any *Insured* receives or expects to receive any compensation or other payment, whether or not related to *Professional Services* rendered, which is a commission, profit-sharing, participation, payment in securities, success fee, or similar kind of payment dependent upon the completion or success of the transaction.

V. **INSURED'S RIGHT TO EXTENDED REPORTING COVERAGE**

A. **Automatic Extended Reporting Coverage**

1. The *Automatic Extended Reporting Coverage* provides coverage for *Claims* that were first made against an *Insured* and reported to the Company within sixty (60) days after the end of the *Policy Period*, and that arise out of any negligent act, error or omission occurring prior to the end of the *Policy Period* and after the *Retroactive Date*, and that are otherwise covered by this Policy.

2. Within thirty (30) days after the effective date of cancellation, the Company will provide the *Named Insured* with written notice of this *Automatic Extended Reporting Coverage*.

B. **Optional Extended Reporting Coverage**

1. The *Optional Extended Reporting Coverage* provides coverage for *Claims* that were first made against an *Insured* and reported to the Company after the end of the *Policy Period*, and that arise out of any negligent act, error or omission occurring prior to the end of the *Policy Period* and after the *Retroactive Date*, and that are otherwise covered by this Policy. The *Named Insured* may purchase *Optional Extended Reporting Coverage*, as described below, because of any of the following events:

- (a) The *Named Insured* cancels or non-renews this Policy; or
- (b) The Company cancels or non-renews this Policy for any reason other than non-payment of premium; or
- (c) The Company cancels this Policy for non-payment of premium or fraud after more than one year of continuous coverage by the Company; or
- (d) The Company has offered to renew this Policy subject to a decrease in the Limits of Liability, a reduction of coverage, an increase in the Deductible(s), a new exclusion, or any other change in coverage less favorable to an *Insured*.

The Company will determine the premium for *Optional Extended Reporting Coverage* upon receipt of the *Named Insured's* request. If the Policy is cancelled due to nonpayment of premium or fraud on the part of an *Insured*, the Company will not provide a premium quotation unless requested by the *Named Insured*. The Limits of Liability for the *Optional Extended Reporting Coverage* are separate from and shall not exceed the Limits of Liability of the last policy in effect.

2. Within thirty (30) days after the effective date of cancellation, the Company will provide the *Named Insured* with written notice explaining the *Optional Extended Reporting Coverage*, the premium charge for the *Optional Extended Reporting Coverage*, and the importance of purchasing *Optional Extended Reporting Coverage* as explained in the New York Notice.

3. Within sixty (60) days after the effective date of cancellation of this Policy or within thirty (30) days after the Company mails or delivers a notice to the *Named Insured*, whichever is greater, the *Named Insured* must exercise in writing the option to purchase *Optional Extended Reporting Coverage* for a three-year period, and must pay the additional premium to the Company upon demand.

4. Where a claims-made relationship has continued between the *Insured* and the Company for at least three (3) years, the aggregate Limit of Liability applicable to the *Optional Extended Reporting Coverage* will equal one hundred percent (100%) of the Policy's last annual aggregate limit. Where a claims-made relationship has continued between the *Named Insured* and the Company for less than three (3) years, the aggregate Limit of Liability for the *Optional Extended Reporting Coverage* will equal the greater of: (i) the

amount remaining in the Policy's last Policy Aggregate Limit of Liability; or (ii) fifty percent (50%) of the last Policy's Policy Aggregate Limit of Liability. Where the cancellation is due only to a decrease in the Policy Aggregate Limit of Liability, the aggregate Limit of Liability applicable to the *Optional Extended Reporting Coverage* shall be no greater than the amount of such decrease.

5. Except where prohibited by law, the premium for the *Optional Extended Reporting Coverage* is fully earned by the Company and the coverage cannot be cancelled.

C. Right of *Qualifying Person* to Purchase *Optional Extended Reporting Coverage*

1. Any *Qualifying Person* may purchase *Optional Extended Reporting Coverage* providing coverage solely to the *Qualifying Person*, but only if all of the following conditions are met: (1) the *Named Insured* has been placed in liquidation or bankruptcy or permanently ceases operations; (2) the *Named Insured* or its designated trustee does not purchase *Optional Extended Reporting Coverage*; (3) the *Qualifying Person* requests the *Optional Extended Reporting Coverage* within one hundred twenty (120) days of the termination of the *Policy Period*; and (4) the *Qualifying Person* pays the additional premium to the Company on demand.

2. The *Named Insured* is responsible for notifying any *Qualifying Partner(s)* of any change in the *Named Insured's* coverage.

D. *Unlimited Extended Reporting Coverage – In Event of Retirement, Permanent Disability, or Death*

1. The *Named Insured* may purchase *Unlimited Extended Reporting Coverage*, as described below, because of any of the following events:

(a) A *Named Insured* who is a sole proprietor becomes *Retired* or *Permanently Disabled*, or a two-professional firm's business is *Discontinued* because one of the professionals becomes *Retired* or *Permanently Disabled*; or

(b) A *Named Insured* who is a sole proprietor dies, or a two-professional firm's business is *Discontinued* because one of the professionals dies.

2. If a firm is *Discontinued* for reasons described in section V.D.1.(a) or V.D.1.(b), above, then within thirty (30) days of such discontinuation the *Named Insured* or the deceased *Insured's* estate has the right to purchase *Unlimited Extended Reporting Coverage* for *Claims* first made against the *Named Insured* and reported to the Company after the end of the *Policy Period* arising out of any negligent act, error or omission occurring prior to the end of the *Policy Period* and otherwise covered by this Policy.

3. *Unlimited Extended Reporting Coverage* under this section V.D. is not available if the *Named Insured* purchases *Optional Extended Reporting Coverage* under section V.B., above.

E. Additional Definitions Applicable to This Section

1. The *Automatic Extended Reporting Coverage Period* is a period of sixty (60) days from the cancellation or termination date of this Policy, during which period any *Claims* that were first made after the *Retroactive Date* may be reported to the Company.

2. The *Optional Extended Reporting Coverage Period* is a period which follows the end of the *Policy Period* in which any *Insured* may first report to the Company any *Claims* that were first made against an *Insured* after the end of the *Policy Period*, and that arise out of acts, errors or omissions committed after the *Retroactive Date*. The *Optional Extended Reporting Coverage Period* begins at the end of the *Policy Period*, if the *Named Insured* purchases such coverage.

3. The *Unlimited Extended Reporting Coverage Period* is an unlimited period, which follows the cancellation or termination date of this Policy because a firm is *Discontinued* for reasons described in section V.D.1.(a) or V.D.1.(b), above, during which period any *Insured* may first report to the Company any *Claims* that were first made against an *Insured* after the end of the *Policy Period*, and that arise out of acts, errors or omissions committed after the *Retroactive Date*. The *Unlimited Extended Reporting Coverage Period* begins at the end of the *Policy Period*, if the *Named Insured* purchases such coverage.

4. A “*Qualifying Person*” is a *Person* who qualifies as an *Insured* under the Policy.

5. “*Retired*” means the *Insured* : (a) has reached age 55, and (b) has completely ceased providing *Professional Services*.

6. “*Permanent Disability*” means the *Insured* is medically judged to be totally and permanently unable to perform each of the material duties of providing *Professional Services*, and has sold or discontinued his/her certified public accounting practice as a result of such disability. Proof of such disability must be provided upon the Company’s request.

7. The business of a two-professional firm is “*Discontinued*” when: (a) both professionals are *Retired*, are *Permanently Disabled* or have died, or (b) one professional has *Retired*, has become *Permanently Disabled* or has died, and the other professional has sold the firm’s business to an unrelated party.

VI. POLICY CONDITIONS

A. *Insured’s Duties Upon Notice of Claim or Potential Claim*

As a condition precedent to coverage, an *Insured* must:

1. Promptly notify the Company or its authorized representative of any *Claim* or *Potential Claim*, and include the following information, if available:

- (a) The name and address of the claimant or potential claimant, and all other involved individuals;
- (b) A description of the *Professional Services* provided, or that should have been provided, and the *Damages* that may result;
- (c) The *Insured’s* explanation of why the *Claim* was made or why the *Potential Claim* may become a *Claim*.

The written notice required hereunder shall be given to the Company by mail, at:

CAMICO Mutual Insurance Company
Claims Department
1235 Radio Road, 2nd Floor
Redwood City, California 94065

Notice given by or on behalf of an *Insured*, or written notice by or on behalf of the injured person or any other claimant, to any licensed agent of the Company in New York, with particulars sufficient to identify an *Insured*, shall be deemed notice to the Company. Failure to provide prompt notice shall not invalidate the *Claim* made if the *Insured* can establish that it was not reasonably possible to give prompt notice and that notice was given as soon as was reasonably possible.

2. Upon receipt of a *Claim*: (i) immediately send to the Company copies of any demands, notices, summonses or legal papers received in connection with the *Claim*; (ii) authorize the Company to obtain records and other information; and (iii) cooperate with the Company in the investigation, defense, and settlement of the *Claim*.

3. Upon request, assist the Company in enforcing any right against any *Person* that may be liable to an *Insured* because of *Damages* to which this insurance applies.

4. Refuse, except at the *Named Insured's* own cost, to admit any liability, assume any *Damages*, voluntarily make any payments, or incur any *Claim Expenses* without the prior written consent of the Company.

5. Upon request, provide information relevant to any *Claim*, and submit to examination(s) by the Company's representative, under oath if requested, regarding any information relevant to any *Claim*.

B. Innocent Insured

1. If coverage for a *Claim* would be void, excluded, suspended or lost as a result of any *Insured's* acts, errors or omissions excluded from coverage by section III. EXCLUSIONS, (a) Intentional Misconduct, then this Policy's coverage will continue to apply to any innocent *Insured* who did not personally commit, participate, or acquiesce or remain passive after having acquired personal knowledge of such acts, errors or omissions, provided that upon acquiring personal knowledge the innocent *Insured* promptly gives notice to the Company in accordance with section I. Insuring Agreements, A. Coverage for *Damages* and Reporting Requirements, and section VI. Policy Conditions, A. *Insured's* Duties Upon Notice of *Claim* or *Potential Claim*.

2. If any coverage for a *Claim* would be void, excluded, suspended or lost by as a result of any *Insured's* failure to comply with the reporting requirements of section I. Insuring Agreements, A. Coverage for *Damages* and Reporting Requirements, and section VI. Policy Conditions, A. *Insured's* Duties Upon Notice of *Claim* or *Potential Claim*, then this Policy's coverage will continue to apply to any innocent *Insured* who did not fail to comply with the reporting requirements of this Policy, provided that:

(a) the innocent *Insured* promptly gives notice to the Company in accordance with the provisions of section I. INSURING AGREEMENTS, A. Coverage for *Damages* and Reporting Requirements, and section VI. POLICY CONDITIONS, A. *Insured's* Duties Upon Notice of *Claim* or *Potential Claim*, and

(b) the *Named Insured* is continuously insured by the Company through the date upon which notice is received by the Company.

3. These provisions do not extend coverage to any *Insured* when coverage is void, excluded, suspended or lost because of any other *Insured's* non-compliance with disclosure of information required on any policy application or policy renewal application.

C. Transfer and Assignment of *Insured's* Rights and Duties

1. No *Insured* may transfer or assign any *Insured's* rights or interest in, or duties under, this Policy without the Company's written consent.

2. If the Company makes any payment for *Damages* and/or *Claim Expenses*, it shall be subrogated to all of the *Insured's* rights of recovery against anyone, and the *Insured* shall do whatever is necessary to secure such rights. After becoming aware of a *Claim* or a *Potential Claim*, no *Insured* shall do anything to prejudice the Company's subrogation rights.

3. Any monetary recoveries will be distributed between the *Named Insured* and the Company in proportion to the amounts paid by the *Named Insured* within the Deductible – Per *Claim* and by the Company within the Limits of Liability.

D. Legal Action Against the Company

1. No *Insured* shall seek to join the Company as a party to a suit that seeks *Damages* from an *Insured* or sue the Company unless: (a) all of the terms and conditions of this Policy have been met, and (b) the amount of the *Insured's* obligation to pay *Damages* has been finally determined either by judgment against the *Insured* after an actual contested trial or by written agreement of the *Insured* and the claimant with the prior written consent of the Company.

2. If an *Insured* and the Company dispute whether this Policy provides coverage for a *Claim*, all *Insureds* agree that the parties will meet with a qualified mediator in a good faith effort to negotiate a resolution of the dispute prior to the initiation of any legal proceeding. The mediation will continue until the dispute is resolved, or until the mediator notifies the parties that it is unlikely that the dispute will be resolved through mediation, or until any party elects to end the mediation after a minimum of thirty (30) days after the first mediation session.

3. In the event that a judgment against an *Insured* or an *Insured's* personal representative in an action brought to recover damages for injury sustained or loss or damage occasioned during the life of the Policy shall remain unsatisfied at the expiration of thirty days from the service of notice of entry of judgment upon the attorney for an *Insured*, or upon an *Insured*, and upon the Company, then an action may, except during a stay or limited stay of execution against the *Insured* on such judgment be maintained against the Company under the terms of the Policy for the amount of such judgment not exceeding the amount of the applicable Limit of Liability under the Policy.

E. Other Insurance

This insurance shall be excess over any other valid and collectible insurance available to any *Insured*, whether such insurance is stated to be primary, contributory, excess, contingent or otherwise. However, this condition does not apply if the other insurance was purchased specifically to apply in excess of this insurance and identifies this Policy as primary insurance.

F. Cancellation or Non-Renewal

1. The *Named Insured* may cancel this Policy by providing written notice to the Company accompanied by surrender of the Policy to the Company or any of the Company's authorized agents, or by mailing written notice to the Company at the location stated VI. POLICY CONDITIONS, A. *Insured's* Duties Upon Notice of *Claim* or *Potential Claim*, paragraph 1. The written notice must state the date on which the *Named Insured* requests cancellation to become effective. The mailing of notice by the *Named Insured* shall be sufficient proof of notice. The time of surrender shall become the end of the *Policy Period*. Hand delivery of such written notice by the *Named Insured* shall be equivalent to mailing.

2. Cancellation of Policies in Effect for Sixty (60) days or less:

If this Policy has been in effect for sixty (60) days or less, the Company may cancel the Policy by mailing or delivering to the *Named Insured* written notice stating the reason for cancellation at the mailing address shown in this Policy, and the authorized agent or broker at least:

(a) Fifteen (15) days before the effective date of cancellation, if the cancellation is based on one or more of the following reasons:

1. Nonpayment of premium;
2. An *Insured's* conviction of a crime arising out of acts increasing the hazard insured against;
3. Acts or omissions by the *Named Insured* or the *Named Insured's* representative constituting fraud or material misrepresentation in the procurement of this policy, in continuing this policy or in presenting a *Claim* under this policy;
4. An act or omission of a policy condition by an *Insured* that substantially and materially increases the hazards insured against;
5. Material change in the risk;
6. Determination by the New York Superintendent of Insurance that the continuation of the policy would place the Company in violation of the insurance laws of this state; would jeopardize the Company's solvency; or would be hazardous to the interest of the Company's policyholders, creditors or the public; or
7. An *Insured's* professional license is revoked or suspended.

(b) Twenty (20) days before the effective date of cancellation if for any reason not stated in paragraph (a), above.

3. Cancellation of Policies in Effect for More than Sixty (60) Days

If this Policy has been in effect for more than sixty (60) days, or if this Policy is a renewal or continuation of a policy issued by the Company, then the Policy may be cancelled by the Company only for one or more of the reasons listed in paragraph F.2.(a), above, providing written notice stating the reason for cancellation is mailed or delivered to the *Named Insured* at the mailing address shown in this Policy, and the authorized agent or broker at least fifteen (15) days before the effective date of cancellation.

4. Return of Unearned Premium

If the *Named Insured* cancels the Policy, earned premium will be computed in accordance with the customary short rate table and procedure. If the Company cancels this Policy, earned premium shall be computed pro rata, and a refund of unearned premium, except a premium that has been financed, shall accompany the notice of cancellation.

5. Non-Renewal

(a) The Company will give the *Named Insured* written notice not less than sixty (60) days nor more than one hundred twenty (120) days prior to the expiration of this Policy if the Company does not intend to renew this insurance, or if the Company intends to condition the renewal upon a change of limits, reduction in coverage, change in type of coverage, increased deductible or addition of exclusion, or upon increased premiums in excess of ten percent (10%). The notice will include the Company's reason for non-renewal or conditional renewal and the effective date of cancellation, and will be mailed or delivered to the *Named Insured* at the last known mailing address and to the *Named Insured's* authorized agent or broker. If notice is mailed, proof of mailing will be sufficient proof of notice.

(b) If either one of the following occurs, the Company is not required to provide written notice of nonrenewal: (i) CAMICO or a company within the same insurance group has offered to issue a renewal policy; or (ii) the *Named Insured* has obtained replacement coverage or agreed in writing to do so.

(c) If the Company's notice of nonrenewal is not timely provided prior to the Policy's expiration date, coverage shall remain in effect at the same terms and conditions of the expiring policy and at the lower of the current rates or the prior period's rates, until sixty (60) days after such notice is mailed or delivered. If prior thereto, the *Named Insured* has replaced the coverage or elects to cancel, such cancellation shall be on a pro rata premium basis. If the Company's notice of nonrenewal is not provided by the Company until on or after the Policy's expiration date, coverage will remain in effect on the same terms and conditions of the expiring policy for another *Policy Period*, and at the lower of the current rates or the expiring *Policy Period's* rates unless the *Named Insured* has replaced the coverage or elects to cancel, in which event, such cancellation shall be on a pro rata premium basis.

G. Change in Risk

The Company has the right to assess and charge an additional premium if, in the reasonable judgment of the Company, there is a significant increase in the size or other risk characteristics of the *Named Insured*.

H. Bankruptcy

The bankruptcy or insolvency of the *Named Insured* will not relieve the Company or any *Insured* of any obligations under this policy.

I. Mutual Policy Provisions: Dividends, Voting, Policy Non-Assessable

1. The *Named Insured* is a member of the Company and shall participate in the distribution of dividends fixed and determined by the Board of Directors.
2. The *Named Insured* is entitled to vote, either in person or by proxy, at all meetings of the Company, pursuant to the Bylaws and Articles of Incorporation of the Company.
3. This policy is not assessable.

J. Entire Contract

By accepting this Policy, each *Insured* agrees that the statements in the Declarations and in each application for renewal or supplementary application are his/her agreements and representations, that this Policy is issued in reliance upon the truth of such representations, and that this Policy embodies all agreements existing between each *Insured* and the Company or any of its agents relating to this insurance.

IN WITNESS WHEREOF, the Company has caused this Policy to be signed by its President and a Secretary and countersigned on the Declarations page by a duly authorized representative of the Company.

PRESIDENT

SECRETARY