



Firm \_\_\_\_\_

**Funds Controlled Supplement** **S-3.2**

1. List total amount of client funds your Firm and Firm affiliates control or disburse annually: \$ \_\_\_\_\_
2. Number of clients: \_\_\_\_\_
3. On a separate sheet please describe nature of the scope of services provided by the Firm and describe internal controls in place for these services.
4. a. Do you provide business/personal management or family office services or control funds for clients in the entertainment industry?  Yes  No  
 If "Yes," provide the number of such clients: \_\_\_\_\_
- b. For each business/personal management or family office client with annual transactions under your control of \$5,000,000 or greater, complete the following and provide a copy of your current engagement letter.

Client Name	Amount of Funds Managed	Description of Services Provided	Engagement Letter in Place?	Discretionary Investment Authority?
	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Number of employees who control or disburse funds for the Firm, Firm affiliates or clients: \_\_\_\_\_
6. Does the Firm or Firm affiliates maintain a bond or form of employee dishonesty coverage?  Yes  No  
 If "Yes," provide a copy of the current Declarations Page for the bond or policy.
7. Does your Firm and Firm affiliates do background checks on employees with signatory authority?  Yes  No  
 N/A (there are no employees with signatory authority)

I recognize that information submitted on this supplement becomes a part of my application for coverage and is therefore subject to all of the representations and conditions of that application.

Signature \_\_\_\_\_ Date \_\_\_\_\_

