



FIRSTBROOK, CASSIE & ANDERSON LTD.

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CANADIAN ASSOCIATION OF INSOLVENCY AND RESTRUCTURING PROFESSIONALS

BY COMPLETING THIS APPLICATION YOU ARE APPLYING FOR PROFESSIONAL LIABILITY INSURANCE COVERAGE WITH CHUBB INSURANCE COMPANY OF CANADA (THE "COMPANY")

COVERAGE IS UNDERWRITTEN ON A MASTER POLICY OR ON A STAND ALONE BASIS. IF A CERTIFICATE OF INSURANCE IS ISSUED TO THE APPLICANT UNDER THE MASTER POLICY OR ON A STAND ALONG POLICY COVERAGE WILL BE ON A CLAIMS MADE BASIS.

QUESTIONS		ANSWERS		
1	Name and Address (including Branch Offices; attach a separate sheet if necessary)			
2	Telephone and Fax numbers	Telephone:	Fax:	
3	Date Firm Established			
4	Total Number of	Licensed Trustees	Other Professional Staff	Non-Professional Staff
5	Annual Gross Receipts –Insolvency & Restructuring Related Services	Consumer	Commercial	Other (describe below*)
		\$	\$	\$
		Describe All Other Related Receipts		
6	Do you engage in any other Business? If so, Describe Business.	<input type="checkbox"/> YES <input type="checkbox"/> NO		
	NOTE – The insurance coverage provided is solely in respect of your insolvency and restructuring practice – if coverage for other Professional Services is required, the Company must confirm in writing its acceptance of any other Professional Services exposures.			
7	Names of Principals / Partners (attach a separate page if necessary)	Name	Qualifications / Date Qualified	Member in good standing of CAIRP?
8	Is Firm a member of CAIRP?			



9	Former Firms	Name of Firm	Date Established	Date Ceased
	(List all former names, firms, partnerships, or similar entities which have been purchased by or evolved into the entity named in Item 1 and for which you may be legally liable for any professional errors and omissions and desire coverage under this policy)			
10	Do you accept insolvency or restructuring mandates without first obtaining a written agreement on the scope of the services to be provided? If so, explain your risk management practices to manage client expectations.	<input type="checkbox"/> NO		
11	Have you or any of your predecessors ever had similar insurance declined or cancelled? If so, give details.	<input type="checkbox"/> NO		
12	Have you or any of your predecessors ever sustained a loss or had a claim made against you or them? If so, give details. There will be no coverage for any such loss or claim.	<input type="checkbox"/> NO		
13	Do you have any reason to anticipate a loss or any claim being brought against you or any of your predecessors? If so, give details. There will be no coverage for any such anticipated loss or claim.	<input type="checkbox"/> NO		
14	In the past five years, has any professional employee been the subject of a formal disciplinary or professional conduct hearing? If so, give details. There will be no coverage for any such loss or claim.	<input type="checkbox"/> NO		
15	Do you have any operations outside Canada? If so, give details.	<input type="checkbox"/> NO		
16	Are you currently insured? If so, give details.	<input type="checkbox"/> NO		
	(a) Insurer			
	(b) Limit/Aggregate			
	(c) Deductible			
	(d) Premium (optional)			



	(e) Expiry Date			
	(f) Retroactive Date			
	(g) Non-Profit D&O Extension	<input type="checkbox"/> NO		
17	Please indicate Each Claim Limit desired for quotation: <input type="checkbox"/> Single Aggregate <input type="checkbox"/> Double Aggregate	<input type="checkbox"/> \$1,000,000	<input type="checkbox"/> \$2,000,000	<input type="checkbox"/> \$3,000,000
		<input type="checkbox"/> \$4,000,000	<input type="checkbox"/> \$5,000,000	
18	Please indicate Self-Insured Retention desired for quotation	<input type="checkbox"/> \$2,500 (Minimum)	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000
		<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$50,000
		<input type="checkbox"/> Other (Please State)	\$	
19	An extension of coverage for \$1,000,000 in the Aggregate is available to include liability where a principal, partner, licensed trustee or other professional acts as a Director or Officer of a non-profit association or corporation without share capital, constituted for charitable, sporting, professional, social and like objectives. (attach a separate page if necessary)	Name of Person	Organization	Organization's Objective
NOTE – any Claim paid under this Outside Directorship Extension will reduce the Annual Aggregate Limit of the Policy available to pay all other Claims reported in the same Policy Period.				

NOTICE

The **Applicant's** submission of this Application does not obligate the Company to issue, or the **Applicant** to purchase, a Certificate of Insurance under a Master Policy or stand alone Policy. The **Applicant** will be advised if the Application for coverage is accepted. Payment of the premium after quotation is necessary to bind the coverage at the limit and deductible quoted for that premium. The **Applicant** hereby authorizes the Company to make any inquiry in connection with this Application.

MATERIAL CHANGE

If there is any material change in the answers to the questions in this Application before the Certificate of Insurance or Policy inception date, the **Applicant** must immediately notify the Company in writing, and any outstanding quotation may be modified or withdrawn.

FALSE INFORMATION

Any person who, knowingly and with the intent to defraud any insurance company or other person, files an application for insurance containing any false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

DECLARATION AND SIGNATURE

The undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application and any attachments or information submitted with this Application, are true and complete. The undersigned agree that this Application and its attachments shall be the basis of a contract should a Certificate of Insurance under a Master Policy or stand alone Policy providing the requested coverage be issued. The Company will have relied upon this Application, its attachments, and such other information submitted therewith in issuing such Certificate of Insurance under a Master Policy or stand alone Policy.

The information provided in this Application is for underwriting purposes only and does not constitute notice to the Company under any Certificate of Insurance or Policy of a **Claim** or potential **Claim**.

Date		Name of Person Completing Form (please print)	
Title		Signature	

2012/11