



GENERAL LIABILITY & PRODUCTS LIABILITY APPLICATION

APPLICANT'S INSTRUCTIONS

- 1) ANSWER ALL QUESTIONS. IF THE ANSWER TO ANY QUESTION IS NONE, PLEASE STATE NONE.
- 2) APPLICATION MUST BE SIGNED AND DATED BY OWNER, PARTNER OR OFFICER.
- 3) BROCHURES, COPIES OF GUARANTEES, WARRANTIES AND HOLD HARMLESS AGREEMENTS FURNISHED BY THE NAMED INSUREDS SHOULD ACCOMPANY THE APPLICATION.
- 4) THE LATEST 10K AND 10Q, OR IF A PRIVATELY HELD BUSINESS, LATEST AUDITED FINANCIAL STATEMENT AND LATEST QUARTER INCOME REPORT SHOULD BE FURNISHED.

Producer			
Street address	City/state	Zip code	Phone number
			Fax number
Mailing address		Email address	

APPLICANT INFORMATION

Name (First Named Insured and other named Insureds):

Street address:	City / state	Zip code	Phone number	Fax number
Mailing address (of first named insured)			Web address	

Applicant operates as an:

- Individual
 Corporation
 Partnership
 Other (Describe):

Inspection (contact/phone)

Accounting records (contact/phone)

COVERAGE REQUESTED

Effective date:		Expiration date:	
Limits of insurance			
General aggregate:	_____	\$	_____
Products and completed operations aggregate:	_____	\$	_____
Each occurrence:	_____	\$	_____
Personal injury and advertising limit:	_____	\$	_____
Fire damage (any one fire):	_____	\$	_____
Self-insured retention (per occurrence or per claim):	_____	\$	_____
Deductible (per occurrence or per claim):	_____	\$	_____

COMPANY HISTORY

Number of years in business: _____

Is the applicant a subsidiary of another entity? Yes No

If yes, please provide details: _____

Does the applicant have any subsidiaries or related entities not listed above?

If yes, please provide details: _____

Have there been any mergers/acquisitions, consolidations or divestitures?

If yes, please describe your obligations for past, present & future liabilities: _____

Has this account ever operated under a different name:

If yes, please attach complete list of prior names and addresses: _____

Complete description of all operations: _____

REVENUES

Estimated gross annual:

Sales/receipts \$ _____ Domestic sales \$ _____ Foreign sales \$ _____

Payroll _____ Domestic payroll \$ _____ Foreign payroll _____

Total sales or receipts for all products and services

Prior 12 months \$ _____ 2nd prior yr \$ _____ 4th prior yr \$ _____

1st prior yr \$ _____ 3rd prior yr \$ _____ 5th prior yr \$ _____

Describe any significant change in product sales mix between any prior year and next year's projection (use additional paper if necessary) _____

Please list all additional Named Insureds and their percentage of total annual gross receipts:

Do you wish to provide your customers with vendors coverage? Yes No

GENERAL INFORMATION I

Yes No
 Have you discontinued or are you considering discontinuing any product to be covered by this insurance?

If yes, please describe: _____

Are any new products planned for sale during the next 12 months?

Do you import component parts?

Do you export products or have foreign operations?

Are any of your products or services known to be used in connection with aircraft/missiles/aerospace?

Are any of your products or services subject to registration/regulation/review by any governmental agency?

GENERAL INFORMATION II		
	Yes	No
Are any of your products (past or present) known to be used in connection with or contain asbestos or silica materials?	<input type="checkbox"/>	<input type="checkbox"/>
Please explain any "yes" answers: _____		
Processing, quality control and recordkeeping		
Do others manufacturer, assemble, package or install products under your name or label?	<input type="checkbox"/>	<input type="checkbox"/>
Do you manufacturer, assemble, package or install products for others under their name or label?	<input type="checkbox"/>	<input type="checkbox"/>
Please explain any 'yes' answers: _____		
Are written quality control and testing procedures followed?	<input type="checkbox"/>	<input type="checkbox"/>
How long are quality control and testing records kept?		
Are you required to file the test results with any regulatory body?	<input type="checkbox"/>	<input type="checkbox"/>
Can you identify your product from those of competitors?	<input type="checkbox"/>	<input type="checkbox"/>
How?		
Do your records indicate when each product was manufactured?	<input type="checkbox"/>	<input type="checkbox"/>
Do your records show to whom and the date each product was sold?	<input type="checkbox"/>	<input type="checkbox"/>
Do your records show who supplied the component parts going into your products?	<input type="checkbox"/>	<input type="checkbox"/>
Do you require certificates from your suppliers evidencing products liability insurance?	<input type="checkbox"/>	<input type="checkbox"/>
Please explain any "no" answers: _____		
Loss prevention, loss control, claim defense		
Who designs your products? _____		
Do you require certificates evidencing design or architects and engineers errors and omissions insurance?	<input type="checkbox"/>	<input type="checkbox"/>
Are designs reviewed, tested and verified by others?	<input type="checkbox"/>	<input type="checkbox"/>
Do you maintain records of changes in designs, advertisements and sales brochures?	<input type="checkbox"/>	<input type="checkbox"/>
Are all instructions, operating manuals, advertisements and warranties periodically reviewed by legal counsel to avoid misunderstandings relative to product safety or intended use?	<input type="checkbox"/>	<input type="checkbox"/>
How often?		
Are your products designed, tested, labeled and manufactured to meet or exceed all applicable government and industry standards?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever draw plans, designs or specifications for any product (s) for others?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, do you carry design or architects and engineers error and omissions insurance?	<input type="checkbox"/>	<input type="checkbox"/>
Have you sold any business in which you retained liabilities?	<input type="checkbox"/>	<input type="checkbox"/>
If so, please furnish details including list of products manufactured, assembled, packaged or installed by you prior to the date sold:		
Do you have a specific program to withdraw known or suspected defective products from the market?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever recalled (either voluntarily or involuntarily) or are you considering recalling any known or suspected defective products from the market?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please provide details: _____		
Do you provide any guarantees, warranties, or hold harmless agreements?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please provide details: _____		
List your memberships in any industry product-standard organizations (ex: ISO 9000):		

GENERAL INFORMATION III

	Yes	No
Any exposure to flammables, explosives, chemicals?	<input type="checkbox"/>	<input type="checkbox"/>
Any exposure to radioactive/nuclear materials?	<input type="checkbox"/>	<input type="checkbox"/>
Do operations involve storing, treating, discharging, applying, disposing, or transporting of hazardous materials? (e.g., landfills, wastes, fuel tanks, etc)	<input type="checkbox"/>	<input type="checkbox"/>
Any machinery or equipment loaned or rented to others?	<input type="checkbox"/>	<input type="checkbox"/>
Any medical facilities provided or doctors employed/contracted?	<input type="checkbox"/>	<input type="checkbox"/>
Is a formal safety program in operation?	<input type="checkbox"/>	<input type="checkbox"/>
Any watercraft, docks, floats owned, hired or leased?	<input type="checkbox"/>	<input type="checkbox"/>
Any sporting or social events sponsored?	<input type="checkbox"/>	<input type="checkbox"/>
Are certificates of insurance required from all subcontractors?	<input type="checkbox"/>	<input type="checkbox"/>
Do your subcontractors carry coverages or limits less than yours?	<input type="checkbox"/>	<input type="checkbox"/>
Any hoists, cranes or mobile equipment owned, operated, maintained or used in your operations?	<input type="checkbox"/>	<input type="checkbox"/>
Explain all 'yes' responses:		

PRIOR CARRIER INFORMATION (LIST LAST 5 YEARS)

	Year ___	Year ___	Year ___	Year ___	Year ___
General liability					
Carrier					
Policy no.					
Policy type	<input type="checkbox"/> CM <input type="checkbox"/> OCC	<input type="checkbox"/> CM <input type="checkbox"/> OCC	<input type="checkbox"/> CM <input type="checkbox"/> OCC	<input type="checkbox"/> CM <input type="checkbox"/> OCC	<input type="checkbox"/> CM <input type="checkbox"/> OCC
Retroactive date					
Policy limits: Occurrence					
Gen. Aggregate					
Premium					
SIR or Deductible					
Expense within policy limit?	<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

Products liability					
Carrier					
Policy no.					
Policy type	<input type="checkbox"/> CM <input type="checkbox"/> OCC	<input type="checkbox"/> CM <input type="checkbox"/> OCC	<input type="checkbox"/> CM <input type="checkbox"/> OCC	<input type="checkbox"/> CM <input type="checkbox"/> OCC	<input type="checkbox"/> CM <input type="checkbox"/> OCC
Retroactive date					
Policy limits: Occurrence					
Prod. Aggregate					
Premium					
SIR or Deductible					
Expense within policy limit?	<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

	Yes	No
Has any insurer ever cancelled, restricted or refused to renew your policy or any coverage in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____		

Has any product, work, accident or location been excluded, uninsured or self-insured from any previous coverage?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____		

CLAIMS HISTORY

Current plus last five years (currently valued hard copy loss runs)

Total aggregates losses, including defense costs:

Policy period	No. of Claims	Total amounts paid		Amounts in reserve		Valuation Date
		Ind	Exp	Ind	Exp	

Describe individual losses, valued \$25,000 or more, including defense costs: _____

Are you aware of any other occurrences, incidents, conditions, defects or suspected defects that may result in claims against you? Yes No

If yes, give details: _____

SPECIFIED PRODUCTS AND COMPLETED OPERATIONS

Only those products and services specified below will be considered for coverage. Refer to key below

Products (specific category)	Applicant Acts as a/an					No. of Years	% Gross Sales	Does applicant		Products sold to				
	M	W	R	I	MR			Install	Repair / Service	W	R	MR	C	O

M = manufacturer R = retailer Mr = manufacturer's rep Other (specify)
 W = wholesaler I = importer C = consumer-direct

SCHEDULE OF HAZARDS

Location	Classification	Class codes	Premium basis

The applicant represents that the above statements and facts are true and that no material facts have been suppressed or misstated.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part hereof.

Applicant: _____ Title: _____

Applicant's Signature: _____ Date: _____

Agent / Broker Name: _____

The applicant further acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation.