

CoverX

The Coverage Experts
www.coverx.com

Producer: _____

Producer Is: Wholesaler Retailer

Address: _____

Telephone: _____

Fax: _____

Excess & Surplus Lines License No.: _____

Email: _____

Proposed Effective Date: _____

If Renewal, Provide Current Policy No.: _____

FLORIDA

3050 NORTH HORSESHOE DRIVE, SUITE 200
NAPLES, FLORIDA 34014
(239) 430-9119 Telephone
(239) 430-9416 Fax
coverxfl@coverx.com Underwriting Email

TEXAS

311 S. JUPITER, SUITE 200
ALLEN, TEXAS 75002
(214) 495-7717 Telephone
(214) 495-7062 Fax
coverxtx@coverx.com Underwriting Email

ILLINOIS

ONE SOUTH WACKER DRIVE, SUITE 2740
CHICAGO, ILLINOIS 60606
(312) 641-0226 Telephone
(312) 641-9858 Fax
coverxil@coverx.com Underwriting Email

BOSTON

TEN POST OFFICE SQUARE SOUTH, SUITE 350
BOSTON, MASSACHUSETTS 02109
(617) 426-6262 Telephone
(617) 426-8488 Fax
coverxma@coverx.com Underwriting Email

Resident or Non-Resident Surplus Lines Licensee Information for Applicant's State of Domicile:

SL License State: _____

SL License No.: _____

SL License Expiration Date: _____

SL Licensee Name: _____

Affiliation with Producer (e.g., Owner, Executive Officer, Employee): _____

SL Licensee Agency Name (if Entity License): _____

APPLICATION FOR SPECIFIED PRODUCTS AND COMPLETED OPERATIONS INSURANCE

APPLICANT'S INSTRUCTIONS:

- Answer all questions. If the answer to any question is NONE, please state "NONE."
- Application must be signed and dated by owner, partner, or officer of Applicant firm.

1. APPLICANT:

a. Full name of all entities to be Named Insured: _____

b. Principal Address: _____

c. Corporation Partnership Proprietorship Other _____

d. Years in business under present name: _____

e. Describe present or prior affiliation with other firms: _____

- f. Proposed effective date for this insurance: _____
- g. Estimate for new policy year: SALES/GROSS RECEIPTS \$ _____

2. SPECIFIED PRODUCTS AND COMPLETED OPERATIONS:

- a. Only those products and services specified below will be considered for coverage.

Product/Service	Applicant acts as:					No. Yrs.	% of Gross Sales	Does Applicant:		Applicant sells to:				
	M	W	R	I	MR			Install?	Repair or Service	W	R	MR	C	O

M= Manufacturer R= Retailer MR= Manufacturers Rep O= Other _____
W= Wholesaler I = Importer C = Consumer Direct

For each product listed above please include, by addendum if necessary, a complete description of the product, including details of the intended use of the product. Also, please attach copies of product brochures or other product advertisements, including stated warranties, guarantees and warning labels or cautionary notices.

- b. Have you discontinued, or are you considering discontinuing any product to be covered by this insurance? Yes No
- c. Do you import parts? Yes No
- d. Do you export products or have foreign operations? Yes No
- e. Are any of your products or services known to be used in conjunction with aircraft/missiles/aerospace? Yes No
- f. Are any of your products or services subject to registration and/or regulation and/or review by any government agency? Yes No

PLEASE EXPLAIN ANY "YES" ANSWERS: _____

3. CLAIM HISTORY: 5 Years or More

- a. Total aggregate losses, from the ground up, including defense costs:

Policy Period	# of claims	Loss Paid	Expense Paid	Loss Reserve	Expense Reserve	Total Incurred

b. Describe all losses valued \$5,000.00 or more from the ground up, including defense costs: _____

c. Are you aware of any other incidents, conditions, circumstances, defects or suspected defects which may result in claims against you? Yes No
If yes, give details: _____

4. **SALES AND MARKETING:**

a. Total Sales or Receipts for all products and services:
Past 12 months \$ _____ 1ST Prior Year \$ _____ 2nd Prior Year \$ _____
Describe any significant change in product sales mix between any prior year and next year's projection: _____

b. Distribution of Products by Region: West Coast _____% East Coast _____% Midwest _____%
Southeast _____% Southwest _____% Other _____%

c. Do you wish to provide your customers with Vendors coverage? Yes No

d. Do you wish to be insured against Purchase Order contractual liability exposure? Yes No

5. **PROCESSING AND QUALITY CONTROL:**

a. Processing

- (1) Do others manufacture, assemble, package or install products under your name or label? Yes No
- (2) Do you manufacture, assemble, package or install products under their name or label? Yes No

PLEASE EXPLAIN ALL "YES" ANSWERS: _____

b. Quality Control and Record Keeping

- (1) How long are quality control and testing records kept? _____
- (2) Are written quality control and testing procedures followed? Yes No
- (3) Can you identify your product from those of competitors? Yes No
- (4) Do your records indicate when each product was manufactured? Yes No
- (5) Do your records show to whom and the date each product was sold? Yes No
- (6) Do your records show who supplied the component parts going into your products? Yes No
- (7) Do you require certificates evidencing Products Liability insurance from suppliers? Yes No

PLEASE EXPLAIN ALL "NO" ANSWERS: _____

LOSS PREVENTION, LOSS CONTROL, CLAIM DEFENSE:

- a. Who designs your products? _____
Relationship to Applicant firm: _____
- b. Are designs reviewed, tested, and verified by others? Yes No
If yes, please identify by whom: _____
- c. Do you maintain records of changes in designs, advertisements and sales brochures? Yes No
- d. Do you maintain records of changes in product labels? Yes No
- e. Are all instructions, operating manuals, advertisements and warranties periodically reviewed by legal counsel to avoid misunderstanding relative to product safety or intended use? Yes No
- f. Are your products designed, tested, labeled and manufactured to meet or exceed all applicable government and industry standards? Yes No
- g. List your membership in any industry product-standard organizations: _____

- h. Do you have a specific program to withdraw known or suspected defective products from the market? Yes No
- i. Have you ever recalled or are you considering recalling any known or suspected defective products from the market? Yes No

7. LIMITS:

- | | LIMITS REQUESTED | PRESENT INSURANCE |
|---|------------------|--|
| a. Limits of Liability: | \$ _____ | \$ _____ |
| b. Deductible S.I.R. | \$ _____ | \$ _____ |
| c. Retroactive Date: | _____ | |
| d. Expiring Premium: | \$ _____ | |
| e. Present Insurer: | _____ | |
| f. Has any Insurer ever cancelled, restricted or refused to renew your product liability insurance?
If yes, please attach details. | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

NOTICE

- 1. THE INSURANCE POLICY THAT YOU ARE APPLYING TO PURCHASE IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED “NONADMITTED” OR “SURPLUS LINE” INSURERS.**
- 2. THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT WHICH APPLIES TO CALIFORNIA LICENSED INSURERS.**
- 3. THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**
- 4. CALIFORNIA MAINTAINS A LIST OF ELIGIBLE SURPLUS LINES INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST.**
- 5. FOR ADDITIONAL INFORMATION ABOUT THE INSURER YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR “SURPLUS LINE” BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE, AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: 1-800-927-4357.**
- 6. IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY THAT YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.**

Date: _____
Insured: _____