



Commercial Information Section

APPLICANT'S NAME: _____

MAILING ADDRESS: _____

AGENCY: _____
AGENT NAME: _____
ADDRESS: _____

EMAIL: _____
PHONE: _____

PROPOSED EFFECTIVE / EXPIRATION DATES:

From: _____ To: _____
 12:01 A.M., Standard Time at the address of the Applicant

PLEASE ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE “**NOT APPLICABLE.**”

1. **Applicant is:** Individual Corporation Partnership Joint Venture Other (Specify): _____
2. **Year business started:** _____
3. **Describe all business operations conducted by applicant:** _____

4. Premises information:

Loc #	BLD #	Street, City, County, State, Zip Code	City Limits	Interest
			Inside	Owner
			Outside	Tenant
			Inside	Owner
			Outside	Tenant
			Inside	Owner
			Outside	Tenant

5. Previous carrier and loss information (last five years):

Check if no losses last five years.

Year	Company	Policy #	Premium
Any other insurance with this company or being sub-mitted? (Please list name[s] and/or policy number[s]):			

Date of Loss	Losses Paid/ Reserved	Description of Loss
Any policy or coverage declined, cancelled or nonrenewed during the prior three years? Why?		

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

FRAUD WARNING:

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

APPLICANT NAME AND TITLE: _____
(PRINT)

APPLICANT'S SIGNATURE: _____ DATE: _____
(Must be signed by active owner, partner or executive officer)

PRODUCER'S SIGNATURE: _____ DATE: _____



PRODUCT LIABILITY QUESTIONNAIRE

PRODUCER: _____

APPLICANT: _____

TYPE OF ENTITY: (Please select one)

Manufacturer:
(Manufacturing/creation of some or all component parts/ingredients)

Assembler:
(Assembly of modular component parts manufactured/created by others)

Re-label Only:
(Applicant does not manufacture, create, assemble or re-package product)

Re-package Only:
(Applicant does not manufacture, create or assemble product)

Other:

Distribution Only:
(Applicant does not manufacture, create, assemble, re-label or re-package product)

Please describe "Other": _____

PRODUCT INFORMATION

Product Name and Brief Description: _____

Intended Purpose/Use: _____

Anticipated Useful Life: _____

Component (in another product)

End-Product (ready for consumption/utilization)

If component, please describe role in final product.

If end-product, please describe its major component parts

(Type; purpose; supplier; foreign or domestic US origin; testing; record-keeping; Applicant's contractual protections/recourse against supplier; supplier's insurance):

Does Applicant DESIGN product? (If yes, please describe) Yes: No:

End-User of Product:

Consumer: Commercial: Industrial:
Scientific: Charity: Government: Military:

Sales:							
Current Year:	\$	_____	Units	1 st Prior Year:	\$	_____	Units
Projected:	\$	_____	Units	2 nd Prior Year:	\$	_____	Units
% Domestic:		_____		3 rd Prior Year:	\$	_____	Units
% Foreign:		_____		4 th Prior Year:	\$	_____	Units
				5 th Prior Year:	\$	_____	Units

Please Fully Describe:	
Any possible use in aircraft, vehicles, medical field, diagnostics, security, military:	

Awareness of Any Known Defects:	_____

Any Product Recalls:	_____

Any Product Tampering:	_____

Flammability / Combustibility / Radioactivity:	_____

Ingested or Invasive to the Body:	_____

Prescription Required:	_____

Certifications / Evaluations:	_____

Certification Denied / Negative Evaluations:	_____

Guarantees and Warranties:	_____

Warning Labels:	_____

Instructions:	_____

INSURANCE COVERAGE

Policy Period	Prior Carrier	Occ. - C/M	Limits	Terms
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please Fully Describe:

Insurance of Others that may be Accessed in Event of a Claim: _____

Vendors Coverage Requested: _____

LOSS AVOIDANCE & CONTROL

Please Fully Describe:

Applicant's Safety Plans: _____

Defective or Damaged Product Procedures: _____

Component Part Procedures: _____

Record Retention for All Aspects of the Applicant's Operations: _____

ADDITIONAL INFORMATION	
Is Applicant now, or was Applicant ever part of a joint venture for product design, manufacture, assembly, packaging, or labeling?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
If Yes, Please Fully Describe:	
Please Fully Describe:	
Any prior Products Marketed / Discontinued: _____	
Any Named Insured Inter-party / Inter-Company Sales: _____	
Merger / Acquisition Activity: _____	

ANY PERSON WHO KNOWINGLY SUBMITS A QUESTIONNAIRE FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS ANY MATERIAL FACT PERTINENT TO THE INSURANCE THAT IS THE SUBJECT OF THIS QUESTIONNAIRE COMMITS A FRAUDULENT ACT WHICH COULD LEAD TO DENIAL OF INSURANCE PROTECTION AND SEVERE CRIMINAL AND CIVIL PENALTIES.

I attest that I understand the above statement and that this Questionnaire has been completed as accurately as possible.

Applicant's Signature: _____
 Name & Title: _____
 Date: _____

Producer's Signature: _____
 Name & Title: _____
 Date: _____