

E-CIGARETTE AND VAPORIZER GENERAL & PRODUCTS LIABILITY APPLICATION

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE IS A CLAIMS MADE AND REPORTED POLICY. THIS POLICY APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSUREDS AND REPORTED IN WRITING TO THE INSURER DURING THE POLICY PERIOD OR THE OPTIONAL EXTENSION PERIOD, IF APPLICABLE. AMOUNTS INCURRED AS CLAIMS EXPENSES SHALL REDUCE AND MAY EXHAUST THE LIMIT OF LIABILITY AND ARE SUBJECT TO THE DEDUCTIBLE. PLEASE READ THIS POLICY CAREFULLY.

BROKER SECTION:

Agency: _____ Phone _____

Broker/Agent: _____ Email: _____

BACKGROUND INFORMATION – PLEASE READ:

1. Please type or print clearly.
2. Answer ALL question completely leaving no blanks. If any questions or part thereof, do not apply, print N/A in the space.
3. If additional space is needed to answer any question fully, please attach a separate page.
4. This application must be completed, dated and signed by a Principal of the Applicant.

I. APPLICANT INFORMATION

a) Name of Applicant (s) (and list all subsidiary Companies) :

b) Mailing Address:

Street:

City: _____ State: _____ ZIP: _____

c) Physical Location(s):

| | Address | City | State | ZIP |
|---|---------|------|-------|-----|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

d) Mobile Phone _____ Website _____

e) Email _____ Contact Name _____

f) Applicant is: Individual Partnership Corporation Joint Venture LLC

Other: _____

g) Date of Incorporation/Start of Operations: _____

h) Applicant(s) operations (please check all that apply):

| | | | |
|-----------------------|--------------------------|------------------------------|--------------------------|
| Manufacturer | <input type="checkbox"/> | Wholesale/Distributor | <input type="checkbox"/> |
| Importer | <input type="checkbox"/> | Exporter | <input type="checkbox"/> |
| Manufacturers Rep | <input type="checkbox"/> | Retail | <input type="checkbox"/> |
| Contract Manufacturer | <input type="checkbox"/> | Other (please specify below) | <input type="checkbox"/> |

i) Gross Sales:

| | BATTERY EXPOSURES Single Cell Batteries, Unsealed and Chargers | HARDWARE/ACCESSORIES (Tanks, Coils, Wicks, Mouth Pieces, Drip Tips, Sealed Mods, etc) | E-LIQUIDS | Total Sales |
|----------------------------------|--|--|-----------|-------------|
| Projected Next 12 months: | USD | USD | USD | USD |
| This Year/YTD: | USD | USD | USD | USD |
| Last year: | USD | USD | USD | USD |

j) Any Foreign Sales? Yes No

If yes, list countries and % of sales?

Is the applicant owned by, affiliated with or working for a Tobacco company? Yes No

II. HARDWARE/COMPONENTS

a) What products do you Manufacture (M), Sell (S) or distribute (D):

| Product Type | M | S | D |
|--|--------------------------|--------------------------|--------------------------|
| E-Cigarettes/ Vaporisers (cigalikes, e hookah pens, aromatherapy inhalers, dry herb vaporiser) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mod with Sealed Batteries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Batteries and chargers (single cell batteries – not including sealed batteries within mods) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Accessories (Tanks, coils, wicks, drip tips, mouthpieces) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heat Not Burn Devices (device designed to consume tobacco) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please describe) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

b) If you are selling or distributing only - who are the manufacturers you work with and their country of origin they are located in?(All must be listed)

c) Are you included as AI on the insurance of your suppliers? Yes No

If you are selling batteries:

d) Do all of the batteries and chargers you distribute/sell come with CE certification or similar? Yes No

e) Do all of the batteries and chargers you sell have a safety mechanism to prevent overcharging? Yes No

f) Do you sell any of the following brands – if so – please enter sales:

E-fest _____
 MXJO _____
 LG _____
 Imren _____

- g) Do you rewrap or sell rewrapped batteries? Yes No
- h) Do you sell charging bags or carry cases Yes No
- i) Where do you source your batteries from:

III. E-LIQUIDS Check if Not Applicable

a) What products do you Manufacture (M), Sell (S) or distribute (D):

| Product Type | M | S | D |
|---|--------------------------|--------------------------|--------------------------|
| Finished E-Liquids (NOTE – mixing of PG/VG, Nicotine and flavourings is considered manufacture of finished e liquids) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Flavorings or Flavoring Extracts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Propylene Glycol or Vegetable Glycerine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Liquid Nicotine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please describe) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

b) Do your liquids contain:

- Tobacco Extracts Yes No
- High Strength Nicotine Salts Yes No
- If liquids contain High Strength Nicotine Salts, are they labelled not for use with high power sub ohm devices? Yes No

c) Are you a member of AEMSA? Yes No

d)

i. If the products you sell are not manufactured by you – please confirm the name of supplier or contract manufacturer and country of origin:

ii. If products are manufactured by you:

1. where do you source your flavoring chemicals, PG/VG and Liquid Nicotine? (List Country of origin and Supplier):

2. are these ingredients USP (US Pharmacopoeia) grade certified or equivalent? Yes No

3. do you purchase these ingredients in bulk? Yes No

4. if so, do you store appropriately and manage expiry dates Yes No
5. do you receive product safety data sheets with your flavors? Yes No
6. are the flavoring extracts you purchase from a 3rd party supplier made specifically for use within e liquids? Yes No

7. where are e-liquids mixed:

| | |
|---|--------------------------|
| Dedicated Clean Room | <input type="checkbox"/> |
| Contracted out to a 3 rd party lab | <input type="checkbox"/> |
| Warehouse | <input type="checkbox"/> |
| Staff only area in store | <input type="checkbox"/> |
| Counter in store or Vape Lounge as required | <input type="checkbox"/> |
| Other (please describe) | |

iii) **Warranties.**

The applicant understands that no coverage shall be afforded to finished products manufactured subsequent to the effective date of any policy issued which is based on this application:

- 1) which the nicotine content has not been tested (by titration or other relevant method) to verify the final content matches the amount declared on the label
- 2) which are not sold in child proof/ tamper proof containers
- 3) which do not have warnings (see section V) on the label
- 4) Nicotine products sold in California without a Prop 65 warning on the label.

The applicant further understands that, as a requirement of coverage, all manufacturers must sterilise their mixing/testing/extraction equipment using FDA approved chemicals or alcohols or via Autoclave system.

Please confirm your acceptance by signing below:

- e) Does your E-liquid contain Taurine, Caffeine or any Stimulants OTHER than Nicotine? Yes No
- i. If yes please list :: _____
- f) Does your e-liquid contain CBD, THC, or other cannabinoids? Yes No
- i. If yes, please list : _____
- ii. What percentage of sales is for Marijuana related products _____

IV. VAPE SHOPS Check if Not Applicable

- a) Are E-liquid flavour combinations mixed by employees only? Yes No
- b) Do you offer free flavor samples? Yes No

- c) If so, are your samples Nicotine free? Yes No
- d) Are the staff appropriately trained on how to handle liquid nicotine and aware of the dangers associated with spillage ? Yes No
- e) Does this location have a hookah lounge or vaping lounge? Yes No
- f) Does this location have any of the following:
- Live Music/DJs**
 - Bouncers/Doormen**
 - Liquor Sold/Served**
 - Fresh Food Service**
- e) Would you like your GL coverage to extend to events in your vaping lounge? Yes No

V. WARNINGS

- a) Do you warn your customers about:
- i. Nicotine and addiction ? Yes No
 - ii. Explosion risk due to overcharging and charging with incompatible devices (including USB, car adaptors and iPhone chargers)? Yes No
 - iii. Toxicity of E-Liquid if spilled on skin? Yes No
 - iv. Dangers of inappropriate storage of batteries (i.e. loose in pocket/handbags)? Yes No
- b) Do you advise how e liquid should be stored and disposed of? Yes No
- c) Do you promote your products as a smoking cessation device? Yes No
- d) Do you promote your products as Healthy or a healthy living choice? Yes No

VI. GENERAL INFORMATION

- a) Have any of your products been discontinued or recalled in the past 5 years, for reasons other than popularity? Yes No
- i. If yes, explain _____
- b) Are you planning to introduce any new products (other than new flavours) in the next 12 months? Yes No
- i. If yes, list product(s) _____
- c) Can your products be identified from those of competitors? Yes No

- d) Do you keep comprehensive sales records for your customers and if so for how long ? (i.e. if asked – could you verify what was sold to a specific customer on a specific date) Yes No

INSURED HISTORY – CLAIMS, LOSSES, INCIDENTS:

- a) Have you had any claims in the past 5 years? Yes No
 If yes, on a separate sheet provide details and attach loss runs
- b) Are you aware of any incident(s) that may result in a claim not reflected in the above question? Yes No
 If yes, explain: _____

VII. COVERAGE HISTORY:

- a) Provide the following for present Liability Insurance. If None, check here:
- i) Carrier: _____ Limits: \$ _____ Premium: \$ _____
 Rate: \$ _____ Term: _____ Deductible/SIR: \$ _____
- ii.) Coverage Form: Occurrence Claims Made Retro Date: _____
- b) Has the applicant ever been declined or refused coverage, or had its coverage cancelled or non-renewed? Yes No
 If yes, explain:

VIII. COVERAGE REQUEST:

- a) Limits of Coverage/Deductibles:

| Coverage | Limits Requested | Deductible Requested | Retroactive Date Requested |
|--------------------|------------------|----------------------|----------------------------|
| Products Liability | | | |
| General Liability | | | |

- b) Do you require a Blanket Vendors Additional Insured Endorsement? Yes No
- c) Do you require an individual Vendors Additional Insured Endorsement? Yes No
 If yes, provide name, address, and any special wording requested by the vendor/distributor:

d) Do you require an individual a Landlord/Lessor Additional Insured Endorsement? Yes No
If yes, provide name, address, and any special wording requested by the landlord/lessor:

e) How did you hear about us? _____

I understand and agree this Application and any supplements attached hereto will be relied upon for issuance of any policy. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to all Lloyd's of London participating syndicates, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Furthermore, I understand that the policy applied for will apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown on the certificate of insurance issued with the policy or certificate on the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy.

I understand this insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

WARNING

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD, AND SUBJECT TO STATE FINES.

THIS APPLICATION MUST BE SIGNED BY APPLICANT WITHIN 30 DAYS OF BINDING. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE

APPLICANT SIGNATURE

TITLE

DATE

REQUESTED EFFECTIVE DATE

PROPERTY INSURANCE APPLICATION

Complete One Per Location

Insured Information:

| | | | | |
|--|--|------------------------------|--|-------|
| Insured Name: | | | | |
| Mailing Address: | | | | |
| City: | | State: | | ZIP: |
| County: | | Number of Years in Business: | | Web: |
| E-Mail: | | Work: | | Cell: |
| Fax: | | | | |
| Entity: <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Joint Venture <input type="checkbox"/> LLC <input type="checkbox"/> Other | | | | |

Physical Location: Same as Mailing Address

| | | |
|----------|--|--------|
| Address: | | |
| City: | | State: |
| ZIP: | | |

Underwriting Information: Requested Effective Date: / /

| | | | |
|--|-------------|--------------------------------------|--|
| Please describe business operations: | | | |
| Construction Type: <input type="checkbox"/> Frame/Brick Veneer <input type="checkbox"/> Masonry <input type="checkbox"/> Metal | | Yr. Built: | # Stories: |
| Square Footage: | | | |
| <i>If building is over 25 yrs. old provide year of updates for:</i> | | | |
| Heating: | Electrical: | Roof: | Plumbing: |
| Distance from Fire Station: Miles | | Distance from Fire Hydrant: Feet | |
| Is the building Sprinklered (Fire Suppression System)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If "Yes", what percentage: % | | | |
| Do you have an alarm? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If "Yes", what type? <input type="checkbox"/> Local Gong <input type="checkbox"/> Central Station: <input type="checkbox"/> Fire and/or <input type="checkbox"/> Burglar | | | |
| If Central Station, what is the name of the alarm company? | | | |
| Have there been any bankruptcies, tax or credit liens against the applicant in the past 5 years? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are there other occupants in the building? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If yes, please describe other business occupants: | | | |
| Is this Location a fulfillment center? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is Property Located within 5 Miles of any coast? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Coverage Information:

| Subject of Insurance | Limit of Insurance | Policy Form | Co-Insurance | Valuation |
|-----------------------------------|----------------------------------|-------------|--------------|-----------|
| Building – If Owned | | Special | 90% | RC |
| Business Personal Property | | Special | 90% | RC |
| Business Income | \$ _____ Per Month/ _____ Months | Special | N/A | RC |
| Tenant Improvements & Betterments | | Special | 90% | RC |
| Outdoor Sign | | Special | 90% | RC |

*** Business Income Coverage may require a Business Income Estimate Worksheet**

Lien Holders/Additional Insured's:

| Name of Lien Holder/Additional Insured | Address | Relationship |
|--|---------|--------------|
| | | |
| | | |

Prior Carrier/Claims:

| Current Insurance Carrier: | | Number of Yrs. Insured: |
|--|---|-------------------------|
| Expiring Premium: | Have you had any claims in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If you answered "Yes", please provide the following information: | | |
| Date of Claim | Description | Amount of Loss |
| | | |
| | | |
| | | |

WARRANTY: I/We warrant to the Company, that I/ We understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy.

Note: This application is signed by undersigned authorized agent of the Applicant(s) on behalf of the Applicant(s) and its owners, partners, directors, officers and employees.

Signatures:

| | |
|---------------------------|---------------|
| Insured Signature: | Title: |
| Printed Name: | Date: |

PROPERTY INSURANCE APPLICATION

Complete One Per Location

Insured Information:

| | | | | |
|--|--|------------------------------|--|-------|
| Insured Name: | | | | |
| Mailing Address: | | | | |
| City: | | State: | | ZIP: |
| County: | | Number of Years in Business: | | Web: |
| E-Mail: | | Work: | | Cell: |
| Fax: | | | | |
| Entity: <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Joint Venture <input type="checkbox"/> LLC <input type="checkbox"/> Other | | | | |

Physical Location: Same as Mailing Address

| | | |
|----------|--|--------|
| Address: | | |
| City: | | State: |
| ZIP: | | |

Underwriting Information: Requested Effective Date: / /

| | | | |
|--|--|--------------------------------------|--|
| Please describe business operations: | | | |
| Construction Type: <input type="checkbox"/> Frame/Brick Veneer <input type="checkbox"/> Masonry <input type="checkbox"/> Metal | | Yr. Built: | # Stories: |
| | | Square Footage: | |
| <i>If building is over 25 yrs. old provide year of updates for:</i> | | | |
| Heating: | | Electrical: | Roof: Plumbing: |
| Distance from Fire Station: Miles | | Distance from Fire Hydrant: Feet | |
| Is the building Sprinklered (Fire Suppression System)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If "Yes", what percentage: % | | | |
| Do you have an alarm? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If "Yes", what type? <input type="checkbox"/> Local Gong <input type="checkbox"/> Central Station: <input type="checkbox"/> Fire and/or <input type="checkbox"/> Burglar | | | |
| If Central Station, what is the name of the alarm company? | | | |
| Have there been any bankruptcies, tax or credit liens against the applicant in the past 5 years? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are there other occupants in the building? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If yes, please describe other business occupants: | | | |
| Is this Location a fulfillment center? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is Property Located within 5 Miles of any coast? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Coverage Information:

| Subject of Insurance | Limit of Insurance | Policy Form | Co-Insurance | Valuation |
|-----------------------------------|------------------------------|-------------|--------------|-----------|
| Building – If Owned | | Special | 90% | RC |
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Lien Holders/Additional Insured's:

| Name of Lien Holder/Additional Insured | Address | Relationship |
|--|---------|--------------|
| | | |
| | | |

Prior Carrier/Claims:

| Current Insurance Carrier: | | Number of Yrs. Insured: |
|--|---|-------------------------|
| Expiring Premium: | Have you had any claims in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If you answered "Yes", please provide the following information: | | |
| Date of Claim | Description | Amount of Loss |
| | | |
| | | |
| | | |

WARRANTY: I/We warrant to the Company, that I/ We understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy.

Note: This application is signed by undersigned authorized agent of the Applicant(s) on behalf of the Applicant(s) and its owners, partners, directors, officers and employees.

Signatures:

| | |
|---------------------------|---------------|
| Insured Signature: | Title: |
| Printed Name: | Date: |

PROPERTY INSURANCE APPLICATION

Complete One Per Location

Insured Information:

| | | | | |
|--|--|------------------------------|-------|-------|
| Insured Name: | | | | |
| Mailing Address: | | | | |
| City: | | State: | | ZIP: |
| County: | | Number of Years in Business: | | Web: |
| E-Mail: | | | Work: | Cell: |
| Fax: | | | | |
| Entity: <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Joint Venture <input type="checkbox"/> LLC <input type="checkbox"/> Other | | | | |

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|----------|--|--------|
| Address: | | |
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| ZIP: | | |

Underwriting Information: *Requested Effective Date:* / /

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| Heating: | | Electrical: | Roof: Plumbing: |
| Distance from Fire Station: Miles | | Distance from Fire Hydrant: Feet | |
| Is the building Sprinklered (Fire Suppression System)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If "Yes", what percentage: % | | | |
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| Have there been any bankruptcies, tax or credit liens against the applicant in the past 5 years? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are there other occupants in the building? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If yes, please describe other business occupants: | | | |
| Is this Location a fulfillment center? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is Property Located within 5 Miles of any coast? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Coverage Information:

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Prior Carrier/Claims:

| Current Insurance Carrier: | | Number of Yrs. Insured: |
|--|---|-------------------------|
| Expiring Premium: | Have you had any claims in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If you answered "Yes", please provide the following information: | | |
| Date of Claim | Description | Amount of Loss |
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PROPERTY INSURANCE APPLICATION

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| Date of Claim | Description | Amount of Loss |
| | | |
| | | |
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Signatures:

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| Insured Signature: | Title: |
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PROPERTY INSURANCE APPLICATION

Complete One Per Location

Insured Information:

| | | | | |
|--|--|------------------------------|--|-------|
| Insured Name: | | | | |
| Mailing Address: | | | | |
| City: | | State: | | ZIP: |
| County: | | Number of Years in Business: | | Web: |
| E-Mail: | | Work: | | Cell: |
| Fax: | | | | |
| Entity: <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Joint Venture <input type="checkbox"/> LLC <input type="checkbox"/> Other | | | | |

Physical Location: Same as Mailing Address

| | | |
|----------|--|--------|
| Address: | | |
| City: | | State: |
| ZIP: | | |

Underwriting Information: *Requested Effective Date:* / /

| | | | |
|--|--|--------------------------------------|--|
| Please describe business operations: | | | |
| Construction Type: <input type="checkbox"/> Frame/Brick Veneer <input type="checkbox"/> Masonry <input type="checkbox"/> Metal | | Yr. Built: | # Stories: |
| | | Square Footage: | |
| <i>If building is over 25 yrs. old provide year of updates for:</i> | | | |
| Heating: | | Electrical: | Roof: Plumbing: |
| Distance from Fire Station: Miles | | Distance from Fire Hydrant: Feet | |
| Is the building Sprinklered (Fire Suppression System)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If "Yes", what percentage: % | | | |
| Do you have an alarm? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If "Yes", what type? <input type="checkbox"/> Local Gong <input type="checkbox"/> Central Station: <input type="checkbox"/> Fire and/or <input type="checkbox"/> Burglar | | | |
| If Central Station, what is the name of the alarm company? | | | |
| Have there been any bankruptcies, tax or credit liens against the applicant in the past 5 years? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are there other occupants in the building? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If yes, please describe other business occupants: | | | |
| Is this Location a fulfillment center? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is Property Located within 5 Miles of any coast? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Coverage Information:

| Subject of Insurance | Limit of Insurance | Policy Form | Co-Insurance | Valuation |
|-----------------------------------|----------------------------------|-------------|--------------|-----------|
| Building – If Owned | | Special | 90% | RC |
| Business Personal Property | | Special | 90% | RC |
| Business Income | \$ _____ Per Month/ _____ Months | Special | N/A | RC |
| Tenant Improvements & Betterments | | Special | 90% | RC |
| Outdoor Sign | | Special | 90% | RC |

*** Business Income Coverage may require a Business Income Estimate Worksheet**

Lien Holders/Additional Insured's:

| Name of Lien Holder/Additional Insured | Address | Relationship |
|--|---------|--------------|
| | | |
| | | |

Prior Carrier/Claims:

| Current Insurance Carrier: | | Number of Yrs. Insured: |
|--|---|-------------------------|
| Expiring Premium: | Have you had any claims in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If you answered "Yes", please provide the following information: | | |
| Date of Claim | Description | Amount of Loss |
| | | |
| | | |
| | | |

WARRANTY: I/We warrant to the Company, that I/ We understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy.

Note: This application is signed by undersigned authorized agent of the Applicant(s) on behalf of the Applicant(s) and its owners, partners, directors, officers and employees.

Signatures:

| | |
|---------------------------|---------------|
| Insured Signature: | Title: |
| Printed Name: | Date: |