



TMHCC Product Liability Supplemental Application

A. Account Information:

Applicant Name: _____

Website: _____

B. General Information:

1. Years in business under current Applicant Name: _____

2. Please provide other names under which Applicant has conducted business:

3. Type of business: Corporation Partnership Proprietorship Other: _____

4. Is the Applicant controlled by, owned by, commonly owned by, affiliated or associated with any other organization? Yes No

If Yes, please provide details.

4. Has any insurer ever canceled, restricted or refused to renew Applicant's liability insurance?

Yes No

If Yes, please provide details.

C. Product Information:

1. Please provide the following information for those products and/or services that Applicant requests coverage.

Note: Only those products and services listed below will be considered for coverage.

Products and Services (or specific categories)	Applicant acts as a/an:					Years Sold	Domestic Gross Sales	Foreign Gross Sales	Total # of Units	Products sold to:				
	M	W	R	I	MR					W	R	MR	C	O
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		\$	\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		\$	\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		\$	\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		\$	\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

M = Manufacturer

W = Wholesaler R = Retailer

I = Importer

MR = Manufacturer's Rep

C = Consumer Direct

O = Other (Please provide details.)

2. Are all products listed in Question C1 above sold under the Applicant's label? Yes No

If No, please provide details.

3. Are any of the Applicant's products listed above explosive, flammable or poisonous, either by itself or combined with other materials? Yes No

4. Are any of the Applicant's products listed above acquired through merger or acquisition? Yes No

5. Could any of the Applicant's products listed above be used in or in connection with the following*:

- a. Pharmaceuticals / OTC / Nutraceuticals / Herbal Products
- b. Building Materials / Construction
- c. Gas or Drilling Operations
- d. Transportation / Transit
- e. Invasive Medical
- f. Chemicals

- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No

***If applicable, please attach Material Safety Data Sheet.**

6. Are any parts of the product(s) purchased from foreign manufacturers?

- Yes No

7. Has the Applicant discontinued or is the Applicant considering discontinuing any product that would be covered by this insurance?

- Yes No

If Yes, please provide details.

8. Will any new products be introduced in the next 12 months?

- Yes No

If Yes, please provide details.

9. Please provide a list of the Applicant's largest clients and the industries served.

Client Name	Industry

D. Operations

1. Please provide total annual gross sales from all products and services listed in Section C - Question 10.

Upcoming Year (Estimate)	SALES		
	United States / Canada	Foreign	Total
Current / Expiring Year	\$	\$	\$
1 st Prior Year	\$	\$	\$
2 nd Prior Year	\$	\$	\$
3 rd Prior Year	\$	\$	\$
4 th Prior Year	\$	\$	\$

If there are any foreign sales, please list the countries where the Applicant's products are sold:

2. Does the Applicant compound ingredients?

- Yes No

3. Does the Applicant assemble the product(s)?

- Yes No

4. Does the Applicant package the product(s)?

- Yes No

5. Does the Applicant distribute products manufactured by others?

- Yes No

If Yes, please answer additional questions below.

a. Does the Applicant directly import any products?

- Yes No

If Yes, please describe the products and provide the corresponding sales and countries of origin.

b. Does the Applicant obtain Certificates of Insurance from each of your manufacturers / suppliers?

- Yes No

c. Is the Applicant included as an Additional Insured-Vendor under each manufacturer's / supplier's Product Liability insurance?

- Yes No

6. If the Applicant is a distributor, does the Applicant's name appear on the product or packaging?

- Yes No

7. Is any of the Applicant's work subcontracted to others?

- Yes No

a. Please state the type of work and the percentage sub-contracted. _____

b. Does the Applicant have a formal written agreement with the Applicant's sub-manufacturers?

- Yes No

If Yes, please attach those sections of the agreement(s) pertaining to Product Liability and Product Liability insurance.

c. Is there a quality control program for all sub-contractors? Yes No

E. Loss Prevention, Designs and Quality Controls

1. Have the Applicant's products ever been subject to inquiry or investigation in relation to product safety by any government agency? Yes No

If Yes, please provide details.

2. Does the Applicant have a written product recall plan? Yes No

If Yes, please attach details.

3. Has the Applicant ever recalled products because of a potential product safety hazard? Yes No

If Yes, please attach details.

4. Does the Applicant carry out its own design work? Yes No

If No, who designs the Applicant's product?

5. Does the Applicant maintain records of design changes and reasons justifying these changes? Yes No

6. Are the Applicant's designs subject to independent external review, testing or certification? Yes No

7. Are the applicant's products designed, tested, labeled and manufactured to meet or exceed all applicable government and industry standards? Yes No

If Yes, please provide details. (i.e. ANSI, ASTM, FDA, ISO, OSHA etc.)

8. Does the Applicant maintain formal written quality control and testing procedures? Yes No

9. Can the Applicant identify its product(s) from those of competitors? Yes No

10. Does the Applicant maintain completed inventory records of shipments and/or deliveries to consignees? Yes No

11. Are serial and/or batch numbers shown on the finished products and shown on shipment invoices? Yes No

12. Can the date of manufacture of each product be identified by the factory number on the product? Yes No

13. Are all instructions, operating materials, advertisements and warranties periodically reviewed by legal counsel to avoid misunderstanding relative to product safety, intended use, product performance, quality, fitness or durability? Yes No

14. Does the Applicant have a written procedure for obtaining information about product complaints, accidents and injuries involving the Applicant's products? Yes No

15. Does the Applicant provide any training or instruction? Yes No

F. Claims Information

1. Have there been any losses, claims or suits against the Applicant or its subcontractors in the past 5 years? Yes No

If Yes, please provide details.

2. Is the Applicant aware of any circumstance, incident or accusation which may give rise to a claim? Yes No

3. Has any insurer ever cancelled, restricted or refused to renew your Product Liability insurance? Yes No

If Yes, please provide details.

4. Has the Applicant ever been involved or named in any class action, multi-claimant or multi-district litigation or lawsuit? Yes No

If Yes, please provide details by attaching a description to this application.

G. Additional Information



H. Information Required as Part of This Application

1. Completed, signed and dated Supplemental Application(s)
2. Completed, signed and dated ACORD Application(s)
3. Currently valued company/carrier loss runs for the past 5 years

I. Signature

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

Applicable in CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in FL Only.

Applicable in KS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: 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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

Applicable in ME, TN, VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

Signature of
Applicant:

_____ Date: _____

Name and Title:

Signature of
Producer:

_____ Date: _____

Name and Title:

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 THAT APPLY 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 LINE INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEBSITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE: www.insurance.ca.gov.
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 NUMBER: 1-800-927-4357.
6. IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY 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'S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.

Insured: _____

Date: _____