



Salt Lake City Area Office
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Chicago Office
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Chicago, IL 60606
800-456-4576 • Fax 888-408-8081

PRODUCTS LIABILITY

General Information

Proposed Effective Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

Applicant's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail: \_\_\_\_\_ County: \_\_\_\_\_

Business Telephone Number: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Physical Location of Business (if different): \_\_\_\_\_

Population within 50 miles: \_\_\_\_\_

Other Locations Used:

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please list any other names the business is or has been known by: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Producer No.: \_\_\_\_\_ Producer's Name: \_\_\_\_\_

Producer's E-mail: \_\_\_\_\_

Detailed description of business activities (specifically, and by location): \_\_\_\_\_

Is this a new business? Yes No If no, how many years have you been in business? \_\_\_\_\_

Applicant is: Individual Corporation Partnership Joint Venture

Other (please describe): \_\_\_\_\_

Annual Payroll: \$ \_\_\_\_\_

Total Number of Employees: \_\_\_\_\_ Full-Time: \_\_\_\_\_ Part-Time: \_\_\_\_\_

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? Yes No

If yes, please tell us:

Employee Name: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Business Telephone No.: ( ) \_\_\_\_\_

Fax: ( ) \_\_\_\_\_ Years with Company: \_\_\_\_\_

Employee's Responsibilities: \_\_\_\_\_

1. Insurance History

Who is your current insurance carrier (or your last if no current provider)? \_\_\_\_\_

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	\$	\$	\$

Has the Applicant or any predecessor or related person or entity ever had a claim?  Yes  No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy?  Yes  No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets?  Yes  No

If the standard markets are declining placement, please explain why: \_\_\_\_\_  
 \_\_\_\_\_

**2. Desired Insurance**

**Limit of Liability - Professional Liability Coverage:**

Per Act/Aggregate		Per Person/Per Act/Aggregate	
<input type="radio"/>	\$50,000/\$100,000	<input type="radio"/>	\$25,000/\$50,000/\$100,000
<input type="radio"/>	\$150,000/\$300,000	<input type="radio"/>	\$75,000/\$150,000/\$300,000
<input type="radio"/>	\$250,000/\$1,000,000	<input type="radio"/>	\$100,000/\$250,000/\$1,000,000
<input type="radio"/>	\$500,000/\$1,000,000	<input type="radio"/>	\$250,000/\$500,000/\$1,000,000
<input type="radio"/>	Other: _____	<input type="radio"/>	Other: _____

**Self Insured Retention (SIR):**  \$1,000 (Minimum)  \$1,500  \$2,500  \$5,000  \$10,000

**3. Business Activities**

1. Person providing accounting and tax services:

- a. Name: \_\_\_\_\_
- b. Address: \_\_\_\_\_

2. Full name of all entities past and/or present to be named as Insureds: \_\_\_\_\_  
 \_\_\_\_\_

Principal address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

3. S.I.C code of business: \_\_\_\_\_

4. Are there any DBA's (Doing Business As):  Yes  No

If yes, please list: \_\_\_\_\_

5. Total sales or receipts for all products and services:

- a. Past 12 months: \$ \_\_\_\_\_
- b. First prior year: \$ \_\_\_\_\_

- c. Second prior year: \$ \_\_\_\_\_
- d. Next year's projections: \$ \_\_\_\_\_
- e. Describe any significant change in product sales mix between any prior year and the next year's projection: \_\_\_\_\_

**6. Specified Products and Completed Operations** – List all products. Only those products specified will be considered for coverage. The following table uses these abbreviations:

M – Manufacturer, W- Wholesaler, R- Retailer, I- Importer, MR- Manufacturers Rep.

C- Consumer, O- Other (describe): \_\_\_\_\_

PRODUCTS AND SERVICES (OR SPECIFIC CATEGORIES)	APPLICANT ACTS AS					No. of years	% of gross sales	DOES APPLICANT		PRODUCTS SOLD TO				
	M	W	R	I	MR			Install	Repair	W	R	C	O	MR
	<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"/>
	<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"/>

7. Have you discontinued, or are you considering discontinuing any product to be covered by insurance?  Yes  No  
If yes, please attach an explanation. \_\_\_\_\_
8. Are any of your products or services known to be used in aircraft, missiles or aerospace?  Yes  No  
If yes, please attach an explanation. \_\_\_\_\_
9. Do you wish to include your customers as additional insureds with vendor's coverage?  Yes  No  
If yes, please attach a list. \_\_\_\_\_
10. Do others manufacture, assemble, package or install products under your name or label:  Yes  No  
If yes, please attach an explanation. \_\_\_\_\_
11. Do you manufacture, assemble, package or install products for others under their name or label:  Yes  No  
If yes, please attach an explanation. \_\_\_\_\_
12. Do you have a quality control and testing procedure:  Yes  No  
If yes, how long are quality control records kept? \_\_\_\_\_
13. Can you identify your product from those of competitors?  Yes  No
14. Can your records show to whom and the date that each product was sold?  Yes  No
15. Do you require your suppliers to show certificates evidencing products liability insurance?  Yes  No
16. Who designs your products? \_\_\_\_\_
17. Are designs reviewed and tested by others?  Yes  No
18. Do you maintain records of changes in designs, advertisements and sales brochures?  Yes  No  
If yes, for how long: \_\_\_\_\_
19. Are all instructions, operating manuals, advertisements and warranties periodically reviewed by legal counsel to avoid misunderstandings relative to product safety or intended use?  Yes  No
20. Are you products designed, tested, labeled and manufactured to meet or exceed all applicable government and industry standards?  Yes  No

21. Do you have a specific program to withdraw known or suspected defective products from the market?  Yes  No
22. Have you ever recalled, or are you considering recalling, any known or suspected defective products from the market?  Yes  No If yes, please attach an explanation.
23. Are you aware of any other incidents, conditions, circumstances, defects or suspected defects which may result in claims against you?  Yes  No If yes, please attach explanation.

**REPRESENTATIONS AND WARRANTIES**

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.
2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.
3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.
4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: \_\_\_\_\_

Dated: \_\_\_\_\_

Applicant:

Agent/Broker:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name