

Thank you for your trust in PPIB to support you with your Insurance needs. We're thrilled to do business with you and help protect what matters most to you. To get started, please follow these steps:

#### **How to Submit Application**

- 1. Complete Application -- Fill out the required information on the next few pages.
- 2. Save Application -- Once completed, save a copy to your computer so you can email it.
- 3. Sign Application -- Ensure it is signed by the business owner, either electronically or printed and signed.
- 4. Submit Application -- Send signed application to submissions@ppibcorp.com.

### What to Expect Next?

After receiving your application, we will send you a confirmation email acknowledging receipt.

Within 3-5 business days, one of our insurance experts will reach out to you with any follow-up questions or a quote, depending on the status of your submission.

If you need the quote expedited, please indicate this when you submit your application via email.

If you need further assistance with the application, or have additional questions, please feel free to contact us at:

PHONE:

Submissions: submissions@ppibcorp.com

415.475.4300

877.655.0123

FAX:

415.475.4303

### Let's Get Started

Fill Out Application on Next Page





### PRODUCTS LIABILITY APPLICATION

BROKER SECTION:				
Agency:	Phone	Phone		
Broker/Agent: Email:				
BACKGROUND INFORMA	ATION – PLEASE READ:			
<ol> <li>Please type or print clearly.</li> <li>Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.</li> <li>If additional space is needed to answer any questions fully, please attach a separate page.</li> <li>This application must be completed, dated and signed by a Principal of the Applicant.</li> </ol>				
A. APPLICANT I	NFORMATION			
1. Name of Applicant (s)	) (and list all subsidiary Companies) :			
•	liability for any location in (3.)? ovide square footage:	□Yes □ No		
5. Telephone:	Website:			
6. Email:	Contact Name:			
* *	Individual Partnership Corporatio	n □Joint Venture LLC		
8. Applicant's Operation  Private Label I	-	-		
9. Date of Incorporation	n/Start of Operations:			
10. ADDITIONAL INS	URED: (Landlord or Lessor) If necessary, add other	names on separate paper.		
NAME:				
ADDRESS:				
Relationship to your	business (Landlord, lienholder):			

# PRODUCTS LIABILITY APPLICATION

### **B. PRODUCTS AND COMPLETED OPERATIONS**

1. List complete description of products manufactured, sold or distributed by the app	licant (attach	product	
brochure, printed website information, labels or other printed descriptive materials): _			
Of what materials or principal components are these composed of?			
2. Do you manufacture* the complete product? If not, what comp purchased by you?		re	
Who are component parts purchased from?			
*If products not manufactured by applicant, are actual manufacturers located in the U	S?		
And if so, do they carry domestic products insurance at limits of \$1MM or greater?	□Yes	□No	
Do you require Certificates of Insurance?	□Yes	□No	
Are any foreign products/components involved?	□Yes	□No	
If so, identify the company of manufacture and country of origin:			
3. Is Vendors Coverage wanted?	□Yes	□No	
4. Will any vendor repackage, re-label or modify your product?	□Yes	□No	
If yes, explain:	<del>_</del>	_	
5. List all products manufactured by the applicant but not sold under its label:			
2. Dist an products manaractured by the apprecian out not sold under its moon.			
6. Number of units sold annually: Average Cost per u	Number of units sold annually: Average Cost per unit:		
7. TOTAL SALES (next 12 months) \$ Prior Years 1 <sup>st</sup> \$ 2 <sup>t</sup>	<sup>nd</sup> \$		
3 <sup>rd</sup> \$ 5 <sup>th</sup> \$			
8. List your top Five (5) Customers:			
1)			
2) 5)			
3)			
9. Any foreign sales?			
If yes, what percentage of sales?%			
List Countries sold to:			

# PRODUCTS LIABILITY APPLICATION

10. Does the applicant install/ apply/ erect the product?	Yes	□No
Do you supervise the assembly of the product?	□Yes	□No
Where is the product assembled?		
11. Any products assembled by the end user?	□Yes	□No
12. List any product that has been discontinued or recalled in the past 5 years and why:		
13. Is there a written products recall plan?	□Yes	□ No
14. Any new products introduced in the past 5 years?	□Yes	□No
If yes, list product(s) and when introduced:		
15. Are any new products proposed for introduction in the next 12 months?  If yes, list product(s)	∐Yes	□ No
16. Can products be identified from those of competitors?  If yes, how?	∐Yes	□No
17. Are any products sold as components for other products?  If yes, indicate uses:	□Yes	□No
18. Could any of your products or services be used on or in connection with:		
pharmaceuticals / cosmetics / vitamins / herbs?	□Yes	□No
aircraft / missile / aerospace?	□Yes	□No
watercraft or offshore?	Yes	□No
transportation / pollution / waste treatment?	□Yes	□No
19. Any hold harmless agreements, warranties, guarantees given to any supplier, distributor, or purchaser?	□Yes	□No
Please explain:		

# PRODUCTS IABILITY APPLICATION

## C. QUALITY CONTROL / LOSS CONTROL

1.	Are your products tested and labeled to meet government and/or industry standards	□Yes	□No				
	If yes, list standards:						
	Any products UL approved?	□Yes	□No				
	Any products FDA approved?	□Yes	□No				
	Any products not approved by UL, FDA, and/or anyone else?	□Yes	□No				
	If yes, by who?						
2.	List your memberships in any industry product – standard organizations (ex. ISO9000):						
3.	Is a written loss control program in effect?	□Yes	□No				
	Any written quality control procedure?	□Yes	□No				
D.	WARNINGS						
1.	Are hazards inherent in the final product, and warnings against foreseeable misuse and abuse, made known						
	to the ultimate user by:						
	-warnings labels at the point of hazards?	□Yes	□No				
	written instructions?	□Yes	□No				
	other means? (If yes, attach details)	□Yes	□No				
E	. EXPIRING CARRIER INFORMATION						
	Carrier: Limits: \$						
	Premium: \$ Rate: \$						
	Term: Deductible/SIR: \$						
	Coverage Form: Occurrence Claims Made Retro Date:						
	Has any carrier cancelled or refused to renew products liability?						
	If yes, explain:						
. CL	AIMS HISTORY						
1.	Any claims in the past 5 years?	□Yes	□No				
	(If yes, attach currently-valued (within past 90 days) loss runs including details)						
2.	Are you aware of any incident(s) that may result in a claim not reflected in question E.1	? \Bullet Yes	□No				
	If yes, explain:						

#### PRODUCTS IABILITY APPLICATION

#### **G. ATTESTATION**

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 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 is not subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

If a Premium Audit is required for this policy, I acknowledge that I will or an authorized representative will attend and provide any information required by the carrier. Full cooperation with the Audit will be provided. I understand the Carrier will request to see my Financial Statements. Non-Compliance with a Premium Audit may result in cancellation of my policy.

Name of Audit Contact:Audit Contact Phone Number:Email Address (Audit)		
	O COMPLETE THE INSURANCE	YS OF BINDING. SIGNING THIS FORM C. COVERAGE BECOMES EFFECTIVE
APPLICANT SIGNATURE	TITLE	DATE
REQUESTED EFFECTIVE DATI	E:	
LIABILITY LIMIT REQUESTED	\$1,000,000 /\$1,000,000	]\$2,000,000/\$2,000,000
Can we email you your poli	i <b>cy</b> (usually within 2-3 weeks)	
One box below must be checked:  I ELECT TO PURCHASE TER	RORISM COVERAGE AT AN A	
_	ASE TEDDODISM COVED ACE	