RT NUTRA APPLICATION

RT Specialty of Illinois
500 West Monroe Street
30th Floor
Chicago, IL 60661

01012015

APPLICANT'S INSTRUCTIONS

1. Answer all questions. If the answer to any question is **NONE**, please state **NONE**.
   Unanswered questions will result in no quote.

2. Application must be signed and dated by owner, partner or officer.

APPLICANT INFORMATION

1. Full name and description of operations (including products) of all entities to be named insured:

_____

_____

_____

2. Business Location & Mailing Address:

   Physical Address:_____

   City _____ County:_____ State:_____ Zip:_____

   Mailing Address _____

   City:_____ County:_____ State:_____ Zip:_____

   Any other locations that require coverage? ___Y ___N (If yes, please attach location schedule)

3. Contact Person:_____ Position:_____

   Phone No.: _____ E-mail:_____

   Website address: _____

4. _____ Corporation _____ Partnership _____ Proprietorship _____ Other

5. Does the applicant have any parent, sister or other affiliate companies? ___Y ___N
   If Yes, are all exposures included on this application? ___Y ___N
   If No, please explain: _____

6. Organization:
   a. Length of time in business: _____
   b. Considering any mergers, acquisitions or divestitures? ___ Y ___ N
   c. Any mergers in the last 5 years? ___ Y ___ N
   d. Any acquisitions in last 5 years? ___ Y ___ N
      with liabilities? ___ Y ___ N
   e. Any divestitures in the last 5 years? ___ Y ___ N
   Explain all "Yes" responses

7. a. Proposed effective date of insurance ____/____/____

   b. Retroactive date requested ____/____/____

   c. LIMITS requested: _____

   _____

   _____

8. Does the applicant plan on any material changes in Products or Operations? ___Y ___N
   If Yes, please explain: _____

9. Is this application for General Liability including Products & Completed Operations, or is it for Products Liability only (check accordingly)? ____ GL&Products; or ____ Products Liability only

SALES and DISTRIBUTION *(for all proposed Named Insureds)*

1. Provide Total Estimated Sales for the coming year_____

2. Last 5 year sales history: Past 12 months/1st prior year

   2nd prior year 3rd prior year

   4th prior year 5th prior year

3. What percentage of sales are U.S. and Canada? _____% What percentage foreign sales? ___%

4. Does the Insured have any other sales for other products/operations that are not listed above?
   ___Yes ____No If yes, please explain_____

5. Are there any inter-company sales? ___Y ___N
   If Yes, have all sales been disclosed above? ___Y ___N
   If No, please explain: _____

BUSINESS OPERATIONS

1. Does the applicant own or operate any facilities that manufacture products? ___Y ___N
   If Yes, does the applicant manufacture 100% of the product they sell? ___Y ___N

2. Does the applicant contract out any manufacturing to others? ___Y ___N
   If Yes, what percentage is contracted to others? _____%
   If Yes, Please list below or attach the names/addresses of Contract Manufacturers:

_____

_____

3. Does the applicant operate as a Contract Manufacturer of others' products? ___Y ___N
   If Yes, are 100% of products sales under their customers' label? ___Y ___N
   If No, what percentage of products are under the applicant's label? ____%

4. Does the applicant sell products under its own product labels? ___Y ___N
   If Yes, what percentage of product sales are under the Insured's own labels? _____%

5. Does applicant sell products under labels of other manufacturers/suppliers, as a distributor? ___Y ___N
   If Yes, what percentage of sales are under suppliers labels? _____%

6. Does the applicant import any products or ingredients? ___Y ___N
   If yes, what percentage of products or ingredients are imported? _____%
   If yes, what percentage are components/ingredients? _____%
   If yes, what percentage are end product? _____%
   If yes, please list or attach the names/addresses of foreign suppliers/manufacturers:

   _____

7. Does the applicant formulate any of the products they sell? ___Y ___N
   If Yes, what percentage of products does the Insured formulate? _____%

8. Do others formulate products for the applicant? ___Y ___N
   If Yes, what percentage is formulated by others? _____%
   If others formulate products sold by applicant; please provide name/address of formulators: _____

   _____

9. Does the applicant services or install any products? ___Y ___N
   If Yes, please explain: _____

10. Is the applicant a member of any of the following organizations?

    AHPA ____ ABC ____ NPA ____ UNPA____ AAHP____ or Other _____

PROCESSING AND QUALITY CONTROL/QUALITY ASSURANCE (QC/QA)

1. Does the applicant maintain written quality control and testing procedures? ___Y ___N

2. How long are quality control and testing records kept? _____Years

3. Does applicant have a full time QC manager that reports to senior management? ___Y ___N

4. Does applicant comply with current Good Manufacturing Practices (cGMPs)? ___Y ___N

5. Can the applicant identify its products from those of competitors? ___Y ___N

6. Do the applicant's records indicate when each product was manufactured? ___Y ___N

7. Do the applicant's records show to whom and the date each product was sold? ___ Y ___ N

8. Do records show who supplied the ingredients going into your products? ___Y ___N ___N/A

9. Are imported products and ingredients tested for contamination and verification that they match what was ordered? ___Y ___N ___N/A

10. Are the applicant's formulas reviewed, tested and verified by outside labs? ___Y ___N ___N/A

11. Does the applicant maintain records of change in formula? ___Y ___N ___N/A

12. Does the applicant maintain record of changes in advertisements and sales brochures? ___Y ___N ___N/A

13. Are all labels, advertisements and warranties reviewed by Legal Counsel to avoid misunderstandings relative to product safety or intended use? ___Y ___N ___N/A

14. Do you obtain certificates evidencing Products Liability insurance from suppliers? ___Y ___N

15. Do you get certificates of insurance from manufacturers naming you a vendor? ___Y ___N
If Yes, please attach copies.

16. Are you named as an additional insured/vendor on the manufacturers' or suppliers' products liability policy? ___Y ___N

17. Are your products formulated, tested, labeled and manufactured to meet or exceed all applicable government and industry standards? ___Y ___N

REGULATORY, DISCONTINUANCE, EVENT REPORTING & RECALL:

1. Are any of your products subject to FDA approval? ___Y ___N
If **Yes**: a. voluntary or mandatory?_____

2. Are you products or operations subject to any other regulatory approval? ___Y ___N
If **Yes**, please provide name(s) of regulatory agencies._____
_____

3. Is the applicant aware of any adverse issues or claims involving the applicant's products or product labels, related to **California Proposition 65**? ___Y ___N

4. Is the applicant familiar with **California Proposition 65**, and, does the applicant believe their products and product labels are in compliance with **California Proposition 65**? ___Y ___N

5. Have you ever discontinued or are you considering discontinuing any product? ___Y ___N
If **Yes**, please describe the product (s), when it was discontinued and why it was discontinued:
_____
_____

6. Does the applicant have formal Adverse Event Reporting(AER) procedures in place? ___Y ___N

7. How many Serious Adverse Events(SAEs) have been reported to you and/or have you reported to the FDA concerning your products in the past 3 years: _____
If any, have any adverse events resulted in remedial actions? ___Y ___N ___N/A

8. Have any of the applicant's dietary supplements ever had an active ingredient that would be defined as a drug by the FDA? ___Y ___N

9. Does the applicant have a specific Recall program in place, to withdraw known or suspected defective products from the market? ___Y ___N

10. Has the applicant ever recalled or considered recalling any known or suspected defective products from the market? ___Y ___N

11. Is the applicant aware of or have any knowledge of any current situation, fact or circumstance, which might lead to a recall under the coverage provided by the Limited Products Withdrawal Expense Endorsement? ___Y ___N

Please attach an explanation to any "**YES"** answers:

CLAIM HISTORY & HISTORICAL INSURANCE COVERAGE

**Please attach 5 years of currently valued, insurance company loss runs*

1. Has the applicant had any claims or circumstances, in the past 5 years, that would apply to the insurance for which they are seeking coverage on this application? ___Y ___N

2. Is (are) any person(s) or organization(s) proposed for this insurance aware of any fact, incident, circumstance, situation, condition, defect or suspected defect which may result in a claim that would fall under the proposed insurance? ___Y ___N

3. Has any insurance company ever cancelled, restricted or refused to renew your insurance, for which you are applying for coverage on this application? ___Y ___N
   If **Yes**, please explain:_____

   _____

4.

	Prior Carrier	Occ/CM	Limits	Policy Term	Premium	SIR/Ded.
1						
2						
3						
4						
5						

SPECIFIC PRODUCT INFORMATION:

1. Do you promote any of your dietary supplements for use in children? ___Y ___N
   If Yes, please advise percentage of product sales: _____%

2. Do you provide any products for use in prenatal or post-natal care? ___Y ___N
   If Yes, please advise percentage of product sales: _____%

3. Are any of your products designed to promote weight loss, muscle enhancement, weight gain or increased metabolism? ___Y ___N
   If Yes, please advise percentage of product sales: _____%

4. Are any of your products designed for sexual performance enhancement? ___Y ___N
   If Yes, please advise percentage of product sales: _____%

5. Are any of your products considered homeopathic remedies? ___Y ___N
   If Yes, please advise percentage of product sales: _____%

6. Do any past, present or planned products contain any of the following**. If yes, please complete the chart below:** **CHECK HERE IF NONE:**_____

INGREDIENTS	SUPPLEMENT/PRODUCT NAME	MILLIGRAMS	$ OR % OF SALES
Androsteredione			
Animal Derived Products			
Aristolochic Acid			
Bitter Orange/Citrus Aurantium/Synephrine			
Butanediol			
Chaparrel			
Chomper			

INGREDIENTS	SUPPLEMENT/PRODUCT NAME	MILLIGRAMS	$ OR % OF SALES
Colloidal Silver			
Comfrey			
DMAA, 1,3-dimethylamylamine			
DMBA, 1,3-dimethylbutylamine			
DHEA – Dehydroepiandrosterone			
Ephedra/Pseudoephedrine/MaHuang			
Gamma Butyrolactone (GBL)			
Gamma Hydroxybutric Acid			
Germander			
Germanium			
Hoodia			
Hydroxycitrate			
Jin Bu Huan			
Kava			
Lobelia			
L-Tryptophan			
Magnolia			
Pennyroyal Oil			
Steroids or Anabolic Hormones			
Tiractricol (TRIAC)			
Hormone Replacement Therapy			
Yohimbe			

And Any Derivatives of the preceding ingredients

BUSINESS CONTRACTS

1. Are all of the applicant's contracts reviewed by an attorney? ___Y ___N
2. Are hold harmless and indemnification agreements favorable or mutual? ___Y ___N
3. Are guarantees and warranty disclaimers favorable or mutual? ___Y ___N

IF EMPLOYEE BENEFITS IS TO BE COVERED, PLEASE SUBMIT THE FOLLOWING:

(*This information MUST accompany this application or no coverage will be afforded.)*

1. Number of employees,
2. Copy of employee handbook,
3. Retro date of current EBL coverage if claims made,
4. Loss history.

PLEASE ATTACH THE FOLLOWING INFORMATION TO THIS APPLICATION:

1. Current financials (at least the most recent annual Income Statement / Profit & Loss Statement)
2. Resume of key employees, risk manager and executive management,
3. Product advertising material,
4. Catalog of products or copies of applicant's product labels, or provide a website where complete list of products can be found. (All products must be included. Coverage consideration will only be given to those products presented.)
5. QC/QA documents, if available,
6. A brief history of the company.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

No fact, incident, circumstance, situation, condition, defect or suspected defect indicating the probability of a claim or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there is knowledge of any such fact, incident, circumstance, situation, condition, defect or suspected defect any claim subsequently emanating therefrom shall be excluded from coverage under the proposed insurance.

This application, information submitted with this application and all previous applications related hereto and material changes to any of the foregoing of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy.

For the purpose of this application, the undersigned authorized agent of the person(s) and organization(s) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this application and in any attachments, are true and complete. The underwriting manager, Company and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

If the information in this application and any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

If the policy for which application is made is for claims made coverage, the undersigned declares that the person(s) and organization(s) proposed for this insurance understand that coverage for which this application is made applies:

(i) Only to “claims” first made during the “policy period”; unless an extended reporting period is exercised. If an extended reporting period is exercised, the policy shall also apply to “claims” first made during the extended reporting period; and

(ii) Unless amended by endorsement, the limits of liability contained in the policy shall be reduced, and may be completely exhausted by “claim expenses” and, in such event, the Company will not be liable for “claim expenses” or the amount of any judgment or settlement to the extent that such costs exceed the limits of liability in the policy and unless amended by endorsement, “claim expenses” shall be applied against the “deductible”.

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. I/We authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

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

Must be signed by the owner, principal, partner, executive officer or equivalent (within 60 days of the proposed effective date).

Applicant’s Signature_____ Date: _____

Name of Applicant: _____

Title: _____

PLEASE NOTE: COMPLETION AND SUBMISSION OF THIS APPLICATION IS FOR THE PURPOSE OF SECURING A PREMIUM QUOTATION ONLY.

AGENT OR
BROKER_____