Program Administrators: Morgan Moore III (mmoore@wwfi.com); Phone: 213-236-4566
Stacy Pointer (spointer@wwfi.com); Phone: 213-236-4575

GeneralStar Beyond Security.

NutraAdvantage™

Worldwide Facilities, Inc. – 725 Figueroa Street, Suite 1900 **–** Los Angeles, CA 90017 **8v11**

APPLICANT:

1. Full name and description of operations for all entities to be named insureds:
   _____
   _____

2. Business Location & Mailing Address:
   Street:_____
   City:_____ County: _____ State:_____ Zip:_____
   Contact Person: _____ Title:_____
   Phone No.: _____ Fax No.:_____
   Website Address: _____ E-mail: _____

3. Length of time in business: _____

4. a) Proposed effective date of insurance ____/____/____
   b) Retroactive date requested ____/____/____
   c) Limits Requested _____
   d) Current Carrier Information _____

5. Indicate percentage of Gross Sales in each of the following areas:
   ____ Manufacturing ____ Wholesale ____ Retail ____ Manufacturers Representative

SPECIFIC PRODUCT INFORMATION:

1. Do you promote any of your dietary supplements for use in children? ___ Y ___ N

2. Do you provide any products for use in prenatal or post-natal care? ___ Y ___ N

3. Gross Sales History:

   Projected _____ Current year _____ 1st prior year _____

   2nd prior year _____ 3rd prior year _____ 4th prior year _____

4. Do any past, present or planned products contain any of the following:

___ Anabolic Hormones
___ Androstenedione
___ Aristolochic Acid
___ Butanediol
___ Chaparral
___ Chomper
___ Colloidal Silver
___ Comfrey
___ Ephedra / Ma Huang
___ Gamma Butyrolactone (GBL)
___ Gamma Hydroxybutyric Acid (GHB)
___ Germander
___ Germanium
___ Hydroxycitrate (HCA)
___ Jin Bu Huan
___ Pennyroyal Oil
___ Steroids
___ Tiratricol (TRIAC)
___ Any Derivatives of Any of the Above Ingredients
___ Any Pharmaceuticals (Prescription or Over-The-Counter)

___ 5-Hydroxytryptophan (5-HTP)
___ Bitter Orange / Citrus Aurantium
___ Dehydroepiandrosterone (DHEA)
___ Hoodia (Hoodia Gordonii)
___ Kava (Kava Kava)
___ L-Tryptophan
___ Lobelia
___ Magnolia (Magnolia Bark)
___ Synephrine
___ Yohimbe (Yohimbine HCl)

Product Categories	Gross Sales	% of Total Sales
Vitamin & Multi-Vitamin Products (Only Contain Vitamin Ingredients, i.e. C, B6, B12, etc)		
Herbal & Botanical Products (Contain Herbal and Botanical Ingredients i.e. Ginkoba, Chromium, Green Tea, Melatonin, Milk Thistle, etc.)		
Weight Gain, Weight Loss, or Sexual Enhancement Products (Products that Promote W.G./W.L./S.E. without any of the below Ingredients)		
Products that Contain Any of the Following Ingredients ** (5-HTP, Bitter Orange, DHEA, Hoodia, Kava, L-Tryptophan, Lobelia, Magnolia, Synephrine, Yohimbe)		
Other Products (Please Describe)		
Totals		**100%**

** Please list all product names that contain any of the listed ingredients: _____

_____

_____

PRODUCT IDENTIFICATION:

1. Please attach your catalog of products or copies of your product labels. (All products must be included. Coverage consideration will only be given to those products presented.)
2. Do you export products or have foreign operations: ___ Y ___ N
   If **Yes,** please explain including percentage (%) of goods and gross sales:
   _____
3. Have you 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:
   _____
   _____

MANUFACTURERS:

1. Are written quality control and testing procedures followed? If so, please attach . ___ Y ___ N
2. How long are quality control and testing records kept? _____ Years
3. Can you identify your product from those of competitors? ___ Y ___ N
4. Do your records indicate when each product was manufactured? ___ Y ___ N
5. Do your records show to whom and the date each product was sold? ___ Y ___ N
6. Do your records show who supplied the ingredients going into your products? ___ Y ___ N
7. Do you have a formal product recall plan? (Please attach a copy) ___ Y ___ N
8. Do you obtain certificates evidencing Products Liability insurance from suppliers? ___ Y ___ N
   Please explain any "**NO**" answers: _____
   _____

PROCESSING AND QUALITY CONTROL:

1. Do others manufacture or package products under your name or label? ___ Y ___ N
   a) Who formulates these products? _____
   _____
   b) Do you obtain certificates of insurance named as an additional insured? ___ Y ___ N
   c) What percentage (%) are manufactured or packaged by others? _____%
2. Do you manufacture or package products for others under their name or label? ___ Y ___ N
   a) What percentage (%) of your gross sales does this reflect? _____%
   b) Is a mutual hold harmless executed? ___ Y ___ N
3. Do you provide any professional services? ___ Y ___ N
   If **Yes**, please provide details: _____
   _____

LOSS PREVENTION, LOSS CONTROL, CLAIM DEFENSE:

1. Do you formulate your own products?,(If not, please provide name and address of formulator.)
   ___ Y ___ N, Details:_____
2. Do you maintain records of all changes in formulas? ___ Y ___ N
3. Are all labels, advertisements and warranties reviewed by legal counsel to avoid misunderstandings relative to product safety or intended use? ___ Y ___ N
4. Do you obtain certificates of insurance from all manufacturers making products that you sell or distribute? ___ Y ___ N
5. Are you named as an additional insured/vendor on the manufacturer's or supplier's products liability policy? ___ Y ___ N
6. Are any of your products subject to FDA approval? ___ Y ___ N
   If **Yes**: a) What products? _____
   b) Attach a copy of most recent FDA inspection.
   c) Has any inspection required any change to your operations? ___ Y ___ N
7. Do you have a specific program in place to withdraw known or suspected defective products from the market? ___ Y ___ N
8. Have you ever recalled or are you considering recalling any known or suspected defective products from the market? ___ Y ___ N
9. Do you comply with Good Manufacturing Practices (GMP)? ___ Y ___ N
10. Are imported products and ingredients tested for contamination and to verify that they match what was ordered? ___ Y ___ N
11. How many adverse events have been reported to you and/or have you reported to the FDA concerning your products in the past 3 years? _____
    a) Have any adverse events resulted in remedial actions? ___ Y ___ N

Please explain any "**Yes"** answers:

_____

_____

CLAIM & LOSS HISTORY:

1. Please attach 5-year currently valued hard copy company loss runs. Including injuries sustained and status of each claim. (Please attach descriptions of any losses over $10,000.)
2. If this business is loss free and less than 1 year old, please attach a letter stating that you are aware of no losses, claims or incidents that may give rise to a claim.
3. Are you aware of any incidents, conditions, circumstances, defects, or suspected defects which may result in claims against you? (If yes, please attach explanation) ___ Y ___ N
4. Has any insurance company ever cancelled, restricted or refused to renew your product liability insurance? ___ Y ___ N
   If **Yes**, please explain: _____

_____

_____

IF HIRED & NON-OWNED AUTOMOBILE LIABILITY COVERAGE IS TO BE PROVIDED, PLEASE COMPLETE THE FOLLOWING:

(*This information MUST be provided or no coverage will be afforded.)*

1. Number of employees: _____
2. Number of employees of applicant who use own autos annually during course of conducting business on behalf of applicant: _____
   a) Description/type of autos driven by employees: _____
   b) Estimated annual mileage for use of all the non-owned autos: _____
3. Does the applicant currently purchase or have an in-force Commercial Auto Policy? ___ Y ___ N
4. Has any claim arising out of the operation of a hired and/or non-owned automobile been made against the applicant within the past five (5) years for which this proposed insurance would apply, or is the applicant aware of any situation, incident, fact or circumstance that may give rise to a hired and/or non-owned auto liability claim within the past five (5) years? ___ Y ___ N
   If **Yes**, please explain: _____

_____

_____

IF EMPLOYEE BENEFITS IS TO BE COVERED, PLEASE COMPLETE THE FOLLOWING: (*This information MUST be provided or no coverage will be afforded.)*

1. _____ Number of Employees
2. ___/___/___ Retroactive Date of Current EBL Coverage if Claims-Made
3. Loss History *(please attach if current or prior EBL coverage existed)*

PLEASE ATTACH THE FOLLOWING INFORMATION TO THIS APPLICATION:

1. Product Labels or Provide Website Links Where Labels are Available (showing all ingredients)
4. Product Advertising Materials (if available)
5. Quality Control Documents (if available)
6. Any Other Supporting Documentation

ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE:

By signing this Application, you represent and agree to each of the following four (4) items:

1. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your firm is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application.
2. Each of the statements and answers given in this Application, are:
   a) Accurate, true and complete to the best of your knowledge;
   b) No material facts have been suppressed or misstated;
   c) Representations you are making on behalf of all persons and entities proposed to be insured;
   d) A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company issued in specific reliance upon these representations.
3. This Application, along with any other Application or Supplemental Applications are hereby deemed to be attached to the policy contract, and incorporated into the policy contract, whether or not any of the other Supplemental Applications are physically attached to a particular copy of the policy contract, and regardless of whether any of the other Supplemental Applications are signed or dated.
4. You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or any other Application or Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.

FRAUD WARNING:

Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.
Completion of this form does not bind coverage. Applicant's acceptance of Company's quotation is required prior to binding coverage and policy issuance. It is agreed that this form shall be the basis of the contract should a policy be issued. And it will be attached to the policy.
An authorized representative who is an active owner, officer, or partner of your firm must sign this Application within thirty (30) days prior to the policy inception date.

Application must be signed and dated by principal, partner, officer or director of the firm.

Applicant's Signature: _____ Date: _____

Title: _____

Agent or Broker: _____

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