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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 (if different from above) _____

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

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

3. Contact Person: _____ Position: _____

Phone No.: _____ E-mail: _____

Company Website address: _____

4. _____ Corporation _____ Partnership _____ LLC _____ Other

5. Do you have any parent, sister or other affiliate companies? _____Y _____N

If **Yes**, please attach detailed information

If **Yes**, are all exposures included on this application? _____Y _____N

If No, please explain or attach details: _____

6. Organization:

a. Length of time in business: _____

b. Any mergers in the last 5 years? _____Y _____N

Explain "Yes" response

8. Please indicate any 3rd party certifications/verifications currently held by your firm:

NPA: _____ Date of latest certification: _____

NSF: _____ Date of latest certification: _____

Other:: _____ Date of latest certification: _____

9. a. Proposed effective date of insurance _____/_____/_____

b. Retroactive date requested _____/_____/_____

c. CGL LIMITS requested: \$ _____ Per Occurrence
\$ _____ General Aggregate
\$ _____ Products Completed Operations Aggregate
\$ _____ Personal Injury / Advertising Injury

10. Current Insurance Program:

a. Carrier: _____

b. Limits (if different from above): _____

c. Deductible (if different from above): _____

d. Expiring Premium: _____



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MANUFACTURING OPERATIONS

Sales Territory	Manufacturing	Contract Manuf.	Wholesale/Distri	Retailer	Licensing/Royalties
USA	%	%	%	%	%
Foreign Sales	%	%	%	%	%

- 1.
2. If applicable and in respect of Contract Manufacturing declared in 1. above, do you manufacture products on behalf of others using your own formulations? ___Y ___N
 If **Yes**, of your Estimated Gross Revenue is comprised of these products? _____%
3. Do you contract out any manufacturing of your products to others? ___Y ___N
 If **Yes**, what % is contracted to others? _____%
4. Do you sell products under your own product labels? ___Y ___N
 If **Yes**, what percentage of product sales are under your own labels? _____%
5. Do you manufacture products for sale under the label(s) of others? ___Y ___N
 If **Yes**, what percentage of product sales are under others' labels? _____%
6. Do you provide consultation on product labeling or formulation for others? ___Y ___N
7. Do you sell products under labels of other manufacturers/suppliers, as a distributor? ___Y ___N
 If **Yes**, what percentage of sales are under suppliers' labels? _____%
5. Do you import any products or ingredients? ___Y ___N
 If **Yes**, what percentage are components / ingredients? _____%
 If **Yes**, what percentage are finished products? _____%

Please list the territories from which you import your products/ingredients below:

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

1. Do you maintain written quality control and testing procedures? ___Y ___N
2. Do you retain quality control and testing records for a minimum number of years? ___Y ___N
3. Do you have a full-time QC manager? ___Y ___N
4. As of the date of this application and to the best of your knowledge, do you comply with current Good Manufacturing Practices - 21 CFR part 111 DS cGMPS? ___Y ___N
5. Do your records indicate when each product was manufactured? ___Y ___N
6. Do your records show to whom and the date each product was sold? ___Y ___N
7. Do your records show who supplied the ingredients going into your products? ___Y ___N



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8. Are imported products and ingredients tested for contamination and verification that they match what was ordered? Y N

9. Do you audit suppliers? Y N

10. Please describe your audit process and frequency:

11. Do you maintain your own lab? Y N

12. Do you maintain records of changes in products? Y N

REGULATORY, DISCONTINUANCE, EVENT REPORTING & RECALL:

1. Are you aware of any adverse issues or claims involving your products or product labels, related to **California Proposition 65**? Y N

2. Do you believe your products and product labels are in compliance with **California Proposition 65**? Y N

3. If yes, do you test all your products for heavy metals to insure that you are in compliance with Prop 65? Y N

4. If yes to #2, do you put the standard Prop 65 warning label language on your product labels? Y N

5. Have you received any 483 Letters from the FDA in the past 5 years? Y N

6. If **Yes**, are all 483s closed and resolved? Y N

a. What was the date of your most recent FDA inspection? _____

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? _____

8. Do you have a specific Recall program in place, to withdraw known or suspected defective products from the market? Y N

9. In the past 5 years, have you recalled any products from the market? Y N

Please attach an explanation to any Yes answer.

10. Are you 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 answer.

RISK MANAGEMENT

1. Do you obtain certificates evidencing Products Liability insurance from suppliers? Y N

2. Do you get certificates of insurance from manufacturers naming you an additional insured vendor? Y N



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3. Please describe your process for review of adverse event reports (AER) or product complaints:

4. Do you provide GMP training for your employees? ___Y ___N

If **Yes**, how many times per year? _____
 Do you contract with a 3rd party for training; or is training in-house and ongoing? ___Y ___N
 Please briefly explain:

CLAIM HISTORY & HISTORICAL INSURANCE COVERAGE

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

1. Have you had any claims or circumstances, in the past 5 years, that would apply to the insurance for which you 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 canceled, restricted or refused to renew your insurance, for which you are applying for coverage on this application? ___Y ___N

If **Yes to any of the above**, please attach explanation.

4.

	Prior Carrier	Limits	Policy Term	Premium	Sales	Deductible (if known)
1						
2						
3						
4						
5						

SALES and DISTRIBUTION (for all proposed Named Insureds)

1. Provide Total Estimated Sales for the upcoming 12 month policy term / year: _____

1st prior year \$ _____
 2nd prior year \$ _____
 3rd prior year \$ _____
 4th prior year \$ _____

2. What percentage of sales are U.S.? _____% What percentage are foreign sales (incl Canada)? _____%

3. Do you employ a multi-level marketing model? ___Y ___N



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4. If there are two or more entities to be insured, are there any inter-company sales? Y N
 If Yes, have all sales been disclosed above? Y N
 If No, please explain: _____

SPECIFIC PRODUCT INFORMATION:

1. Do you promote any of your dietary supplements for use by 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. Please specify what percentage of your Estimated Gross Revenue relates to each of the following categories:

	Vitamins & Minerals	Pro/Prebiotics/Oils	Herbs
Estimated Gross Revenue for Next Year	\$	\$	\$
Percentage change from Last Year (+/- %)	%	%	%

6. In respect to % of Herbal Ingredients declared in #5 above, do any past, present or planned products contain any of the following? If yes, please complete the chart below. **Please note that coverage is not automatically included for the products listed in the table below.**

INGREDIENTS	SUPPLEMENT/PRODUCT NAME	\$ OR % OF SALES
Germander		
Lobelia		
Yohimbe		
Jin Bu Huan		
Hydroxycitrate		
Colloidal Silver		
Comfrey		
Herbs with teratogenic properties		
Herbs with mutagenic properties		
Citrus Orange/Bitter Orange/ Citrus Aurantium		
Green Tea		

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Guarana		
St John's Wort (Hypericum Perforatum)		
Kava		
Magnolia or any Magnolia derivatives		
Aristolochia		
Stephania		
Caffeine (more than 350mg)		

And Any Derivatives of the preceding ingredients

PLEASE NOTE THAT COVERAGE WILL EXCLUDE THE FOLLOWING, AND/OR DERIVATIVES OF, THE FOLLOWING PRODUCTS:

- Ephedrine, Ephedra & Ma Huang
- DMAA, 1,3- Dimethylamylamine
- DMBA, 1,3- Dimethylamylamine
- Winstrol

NOTICE TO THE APPLICANT – PLEASE READ CAREFULLY

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 30 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 _____