

NUTRA APPLICATION

Sadler & Company, Inc.
3014 Devine St
2nd Floor
Columbia, SC 29205

10232012

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

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: _____

3. Contact Person: _____ Position: _____

Phone No.: _____ Fax No.: _____

Website address: _____ E-mail: _____

4. _____ Corporation _____ Partnership _____ Proprietorship _____ Other

5. 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?
with liabilities? _____ Y _____ N

e. Any divestitures in the last 5 years? _____ Y _____ N

Explain all "Yes" responses

6. a. Proposed effective date of insurance / /
 b. Retroactive date requested / /
 c. LIMITS requested: _____

SALES and DISTRIBUTION

Products	On Market Since	Current year \$	1 st Prior Year \$ (*)	2 nd Prior Year \$ (*)	3 rd Prior Year \$ (*)	4 th Prior Years \$ (*)

** include any discontinued products*

Total Estimated Sales for the coming year _____

Last 5 year sales history: Current year
 2nd prior year 3rd prior year
 4th prior year 5th prior year

7. Indicate percent each of the following areas:
 _____ Manufacturing _____ Distribution _____ Packaging
8. Indicates percent sales:
 _____ Wholesale _____ Retail _____ Mfg. Rep.

PRODUCT IDENTIFICATION

1. Please attached 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. What percentage of your products are manufactured overseas? _____
 a. % of total goods purchased from foreign suppliers: _____
 b. Of total, indicate % that is end product: _____
 c. Of total, indicate % that is Component: _____
3. Do you export products or have foreign operations: ___ Y ___ N
 If **Yes** please explain including percentage (%) of goods and sales volume

4. 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? Y N
If so, please attach a copy.
2. How long are quality control and resting records kept? _____ Years
3. Do you have a full time quality control manager that reports to senior management? Y N
4. Can you identify your product from those of competitors? 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
8. Do you obtain certificates evidencing Products Liability insurance from suppliers? Y N
9. Do you have a formal product recall plan? (Please attach a copy) Y N

Please explain any "NO" answers: _____

DISTRIBUTORS

1. Do you get certificates of insurance from manufacturers naming you a vendor? Y N
If **Yes**, please attach copies.

2. Please provide a list of manufacturers and where they are located: _____

3. Do your records indicate when each product was manufactured? Y N
4. Do your records show to whom and the date each product was sold? Y N
5. Do you obtain certificates evidencing Products Liability insurance from suppliers? Y N
6. Do you have a formal product recall plan? (Please attach a copy) Y N

PROCESSING AND QUALITY CONTROL

1. Do others manufacture or package products under your name or label? Y N

- a) Who is doing the formulating? _____
- 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 revenue does this reflect? _____ %
- b) Is a mutual hold harmless executed? ___ Y ___ N
If not, please advise the nature of the agreement _____
3. Have any of the Applicant's products or ingredients or components thereof, ever been the Subject of any investigation, enforcement action, or notice of violation of any kind by any governmental, quasi-governmental, administrative, regulatory or oversight body: ___ Y ___ N
4. Are you involved with acupuncture? ___ Y ___ N

If **Yes**, please provide details: _____

LOSS PREVENTION, LOSS CONTROL, CLAIM DEFENSE

1. Do you formulate your own products, if not advise name and address of formulator? _____
2. Are formulas reviewed, tested and verified by outside labs? ___ Y ___ N
3. Do you maintain records of change in formula? ___ Y ___ N
4. Do you maintain record of changes in advertisements and sales brochures? ___ Y ___ N
5. Are all labels, advertisements and warranties reviewed by Legal Counsel to avoid misunderstandings relative to product safety or intended use? ___ Y ___ N
6. Do you obtain certificates of insurance from all manufacturers making products that you sell or distribute? ___ Y ___ N
7. Are you named as an additional insured/vendor on the manufacturers or supplier's products liability policy? ___ Y ___ N
8. Are your products formulated, tested, labeled and manufactured to meet or exceed all applicable government and industry standards? ___ Y ___ N
9. Are any of your products subject to FDA approval? ___ Y ___ N
If **Yes**: a. voluntary or mandatory? _____
b. what products? _____
c. attach copy of most recent FDA inspection.
10. Are you products or operations subject to any other regulatory approval? ___ Y ___ N
If **Yes**, please provide name(s) of regulatory agencies. _____
- _____
- _____

11. Are you a member of any of the following organizations?

AHPA ____ ABC ____ NPA ____ UNPA ____ AAHP ____

12. Do you have a specific program to withdraw known or suspected defective products from the market? ____ Y ____ N

13. Have you ever recalled or are you considering recalling any known or suspected defective products from the market? ____ Y ____ N

14. Do you comply with Good Manufacturing Practices (GMP)? ____ Y ____ N

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

16. 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 _____

17. Have any adverse events resulted in remedial actions? ____ Y ____ N

18. Have any of your dietary supplements ever had an active ingredient that would be defined as a drug by the FDA? ____ Y ____ N

19. 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 explain any "YES" answers:

HISTORICAL INFORMATION

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

CLAIM HISTORY

	Years(s)	No. of Claims	Total Paid	Total Reserve	Incurred	Date of Loss
1						
2						
3						
4						
5						

- a. Please attach description of any losses over \$10,000
 - b. Are you aware of any other incidents, conditions, circumstances, defects, or suspected defects which may result in claims against you? Y N
(If yes, please attach an explanation)
1. Please attach 5-year currently valued hard copy company loss runs. Including injury sustained and status of each claim.
 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 Products Liability claim, such tht would fall under the proposed insurance? Y N
 3. Has any insurance company ever cancelled, restricted or refused to renew your product liability insurance? Y N

If **Yes**, please explain: _____

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. Are any of your products designed to promote weight gain, weight loss, muscle enhancement or increased metabolism? Y N
If yes, please list all product names and total projected sales for these Products.
4. Are any of your products used for sexual performance enhancement? Y N
If yes, please list all product names and total projected sales for these products.

5. Do any past, present or planned products contain any of the following. **Please indicate which ones along with product name, estimated sales percentage and milligrams in the products:** **CHECK HERE IF NONE:** _____

INGREDIENTS	PRODUCT NAME	MILLIGRAMS	\$ OR % OF SALES
Androsteredione			
Animal Derived Products			
Aristolochic Acid			
Bitter Orange/Citrus Aurantium/Synephrine			
Butanediol			
Chaparrel			
Chomper			
Colloidal Silver			
Comfrey			
DHEA – Dehydroepiandrosterone			
Ephedra/Pseudoephedrine/MaHuang			
Gamma Butyrolactone (GBL)			
Gamma Hydroxybutric Acid			

INGREDIENTS	PRODUCT NAME	MILLIGRAMS	\$ OR % OF SALES
Germander			
Germanium			
Hoodia			
Hydroxycitrate			
Jin Bu Huan			
Kava			
Lobelia			
L-Tryptophan			
Magnolia			
Pennyroyal Oil			
Steroids or Anabolic Hormones			
Tiractricol			
Hormone Replacement Therapy			
Yohimbe			

And Any Derivatives of the preceding ingredients

PRODUCTS & COMPLETED OPERATIONS

1. Do you install service or demonstrate products? Y N
2. Is research & development conducted or new products planned? Y N
3. Do you have guarantees, warranties or hold harmless agreements? Y N
4. Does any named insured sell to other named insured's? Y N

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

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

1. No. 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 financial statements
(Latest annual Income Statement and Balance Sheet or , if a new company, estimated first years sales),
2. Resume of key employees, risk manager and executive management,
3. Product advertising material,
4. Product labels, (reflecting ingredients),
5. Quality control document, 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 _____