

## MANUFACTURERS PRODUCTS POLLUTION (MPP) APPLICATION FOR GENERAL LIABILITY AND POLLUTION

SECTION I: APPLICANT					
NAME OF APPLICANT				DATE / /	
MAILING ADDRESS					
CITY			STATE		ZIP CODE
TELEPHONE		FAX		WEB ADDRESS	
CONTACT NAME			TITLE		
Company is an: <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> CORPORATION <input type="checkbox"/> JOINT VENTURE <input type="checkbox"/> OTHER:					

**PLEASE SUBMIT THE FOLLOWING INFORMATION IN ADDITION TO THIS APPLICATION IN ORDER TO BE CONSIDERED:**

- 1) Two years of Audited Financial Statements including income statement and balance sheet
- 2) Five years of currently valued loss runs (GL, EIL, Products Liability, and/or Products Pollution Liability)
- 3) Standard Warranty/Quality Control Procedure
- 4) Any existing site specific environmental assessment reports (Phase I, Phase II, etc.)
- 5) Schedule of all owned locations

SECTION II: CURRENT COVERAGE						
Coverage	Current Carrier	Effective Dates	Limits	Retention	Retroactive Date	Premium
General Liability		to	\$ / \$	\$	/ /	\$
Pollution		to	\$ / \$	\$	/ /	\$
Excess		to	\$ / \$	\$	N/A	\$
Auto		to	\$ / \$	\$	N/A	\$

1. Indicate current type of pollution coverage carried.
 

<input type="checkbox"/> Contractors Pollution <input type="checkbox"/> On-Site Pollution <input type="checkbox"/> Third Party Site Pollution <input type="checkbox"/> Products Pollution <input type="checkbox"/> Transportation Pollution <input type="checkbox"/> Other: _____	Coverage Trigger <input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made <input type="checkbox"/> Claims Made <input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made
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2. Has any insurance company ever denied, canceled, or non-renewed general liability or pollution liability coverage?  Yes     No  
 If yes, please explain.

**SECTION III: GENERAL INFORMATION**

1. Year the Insured was established: \_\_\_\_\_
2. Has the Insured ever operated under another name?  
If yes, please explain.  Yes  No
3. Has the Insured acquired, merged, or discontinued any operations in the last five (5) years?  
If yes, please explain.  Yes  No
4. Does the firm have any of the following seeking coverage under this application?  
 Subsidiaries  Parent Company  Other Related Entities  Yes  No  
If yes, explain below.

Named Insured/Subsidiary Company	Description of Operations	Revenues
		\$
		\$
		\$
		\$

5. Total gross revenue for the next 12 months \$ \_\_\_\_\_ Foreign \_\_\_\_\_%  
 1<sup>st</sup> prior year's gross revenue \$ \_\_\_\_\_ Foreign \_\_\_\_\_%  
 2<sup>nd</sup> prior year's gross revenue \$ \_\_\_\_\_ Foreign \_\_\_\_\_%

**SECTION IV: PRODUCTS INFORMATION**

1. List your primary products or product categories.

Product Name	Use or Application	Years on the Market	% of Sales
			%
			%
			%
			%

2. Are or could any of your products or services be part of, used on, or in connection with the following?  
If yes, please provide percentage of sales below.

Industry/Product Type	% of Sales	Industry/Product Type	% of Sales
Aircraft/Missile/Aerospace <input type="checkbox"/> Yes <input type="checkbox"/> No	____%	Oil/Gas <input type="checkbox"/> Yes <input type="checkbox"/> No	____%
Watercraft/Offshore <input type="checkbox"/> Yes <input type="checkbox"/> No	____%	Energy (other than oil/gas) <input type="checkbox"/> Yes <input type="checkbox"/> No	____%
Pharmaceutical <input type="checkbox"/> Yes <input type="checkbox"/> No	____%	Consumer Goods <input type="checkbox"/> Yes <input type="checkbox"/> No	____%
Cosmetics/Health & Beauty/Personal Care <input type="checkbox"/> Yes <input type="checkbox"/> No	____%	Medical/Life Support <input type="checkbox"/> Yes <input type="checkbox"/> No	____%
Pesticides/Herbicides/Fertilizers <input type="checkbox"/> Yes <input type="checkbox"/> No	____%	Animal or Human Foods <input type="checkbox"/> Yes <input type="checkbox"/> No	____%

3. Please provide description of operations based on percentage of sales.

	% of Sales
Product mixing or blending	%
Product distribution with no mixing, blending, or repackaging	%
Product distribution with repackaging or labeling	%
Product manufacturing to own specifications	%
Product manufacturing to customer specifications	%
Product manufactured/processed by third parties	%
Broker/drop ship (no physical possession of product)	%
Other                      Please describe. _____	%

4. Are the products designed by you?  Yes  No

5. Do you install, maintain, or repair your products?  Yes  No  
 If yes, please explain which products and services you provide.

6. Are any components of your products foreign made?  Yes  No  
 If yes, please explain.

7. Has your product ever been subject to any inquiry or investigation by any Governmental Agency concerning the efficiency, adequacy or labeling, hazardous content or safety?  Yes  No  
 If yes, please attach full details and result of such inquiry.

8. Have you ever, or do you currently produce, distribute, transport, store or sell products that contain MTBE (Methyl Tertiary Butyl Ether)?  Yes  No  
 If yes, please explain.

9. How are your products transported?     Trucks (owned)     Trucks (3<sup>rd</sup> party carrier)     Rail     Watercraft     Aircraft

**10. Regarding Quality Control of your products:**

A. Are written quality control and testing procedures followed for raw materials, works in progress, or finished products?  Yes  No  
 If yes, how long are quality control and testing records kept? \_\_\_\_\_

B. Can you identify your product from competitors?  Yes  No

C. Do your records indicate when each product was manufactured?  Yes  No

D. Do your records show to whom and the date each product was sold?  Yes  No

E. Do your records show who supplied the component parts going into your products?  Yes  No

**11. Regarding Loss Control for your products:**

A. Do you have a written products safety program for which specific individuals have responsibility for implementation?  Yes  No

B. Do suppliers and distributors of your product hold you harmless or insure you?  Yes  No  
 If yes, please explain.

- C. Are any of the suppliers, distributors or dealers affiliated with you?  
If yes, please list.  Yes  No
- D. Are your products designed, tested, labeled and manufactured to meet or exceed all applicable government and industry standards?  Yes  No
- E. Are guarantees and/or warranties issued to purchasers?  
If yes, for what period of time do you guarantee and/or warrant your product(s)?  Yes  No
- F. Do you provide training or instruction in the use of any product?  Yes  No
- G. Do you have a specific program to withdraw known or suspected defective products from the market?  Yes  No
- H. Have you ever recalled or are you considering recalling any products?  
If yes, please explain.  Yes  No

12. List your memberships in any industry product-standard organizations, trade associations, or professional associations.

**SECTION V: EXCESS COVERAGE**

Excess Limit Request: \$ \_\_\_\_\_

**Present Coverages**

	Auto Liability	Employers Liability	Excess
Carrier			
Limits			
Retention	\$ _____	\$ _____	\$ _____
Policy Term	/ / - / /	/ / - / /	/ / - / /
Premium	\$ _____	\$ _____	\$ _____

**Auto Liability Information**

Vehicle Type by Gross Vehicle Weight	Number of Power Units		<input type="checkbox"/> Yes <input type="checkbox"/> No
Private Passenger		1. Do you have an auto safety and training program in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Light (<10,000 lbs.)		2. Do you check drivers' MVRs on an annual basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medium (10,001 lbs.-20,000 lbs.)		3. Do you have a vehicle maintenance program in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heavy (20,001 lbs-45,000 lbs)			
Extra Heavy (>45,001 lbs.)			

**SECTION VI: PREMISES INFORMATION**

1. Do you have any tenants at any of your owned or operated premises?  
If yes, please explain.  Yes  No
2. Do you conduct public tours at any of your owned or operated premises?  Yes  No
3. List proposed covered locations for site pollution below.

Location Address	Description of Operations at Premises	Retroactive Date
		/ /
		/ /
		/ /
		/ /

Complete Section VII for each proposed covered location for which you are seeking premises pollution coverage.  
Copy as necessary

**\*\*Please provide any environmental site assessments and spill prevention/response plans for this location.\*\***

**SECTION VII: PROPOSED COVERED LOCATION INFORMATION**

Facility Name: \_\_\_\_\_ How long have you been at this address: \_\_\_\_\_ years

Address: \_\_\_\_\_

1. Describe current operations and if any products are manufactured at or distributed from this location.

2. Describe known historical operations. \_\_\_\_\_

3. Please describe adjacent properties:

North: \_\_\_\_\_

South: \_\_\_\_\_

East: \_\_\_\_\_

West: \_\_\_\_\_

Distance to nearest body of water: \_\_\_\_\_

Type of water body (pond, river, stream, etc.): \_\_\_\_\_

Number of groundwater wells: \_\_\_\_\_

Type of well (drinking or monitoring): \_\_\_\_\_

4. Is there any onsite waste disposal at this location?  
If yes, please explain.

Yes  No

5. Are there any plans for future development of this location?  
If yes, please explain.

Yes  No

6. Are there any hazardous materials/chemicals used, treated, or stored?  
If yes, please explain.

Yes  No

**Storage Tanks**

Type (Aboveground or Underground)	Year Installed	Capacity in Gallons	Contents	Secondary Containment

**Compliance History**

1. Are you aware of any notices of violations, fines, penalties, complaints, or received any claims or suits relating to any pollution conditions?  
If yes, please explain.

Yes  No

2. Are you aware of any past or present pollution conditions or any circumstances which may reasonably be expected to give rise to a claim?  
If yes, please explain.

Yes  No

3. Are you aware of any non-compliance with any local, state, or federal environmental regulations, standards, or statutes?  
If yes, please explain.

Yes  No

**SECTION VIII: ADDITIONAL REQUESTS**

Please list any additional coverage requests.

To be considered for auto liability coverage, please provide the ACORD Auto application and currently valued loss runs.

**SECTION IX: CLAIMS HISTORY**

1. Has any claim, suit or notice of incident been made previously (last five years) against the Applicant (or Predecessor)?  Yes  No

If yes, please include the following in the description:

- a) the date when the claim was made
- b) the date of the incident, act or omission giving rise to the claim
- c) name of the claimant
- d) nature of the claim
- e) amount paid or estimated to be paid
- f) current status and/or final disposition of claim

*\*Use additional paper if necessary.\**

2. Has any member of the applicant, or predecessor firm or any entity that the applicant wholly or partly owns, manages and/or controls aware of any circumstances that may result in any claim, suit or notice of incident or occurrence against them?  Yes  No

If yes, please provide details on additional paper.

3. Has any member of the applicant, or predecessor firm or any entity that the applicant wholly or partly owns, manages and/or controls been the subject of a disciplinary action as a result of their professional activities?  Yes  No

If yes, please provide details on additional paper.

**CURRENTLY VALUED LOSS RUNS MUST BE FURNISHED**

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION INCLUDING ATTACHMENTS, ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED IN THIS APPLICATION OR CONCEALED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT. SUCH AN ACT IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

_____ Name of Insured	
_____ Signature of Owner, Partner or Officer	_____ Signature of Broker/Agent
_____ Print Name	_____ Print Name
_____ Title	_____ Agency Name
_____ Date	_____ Date