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E-CIGARETTE AND VAPORIZER GENERAL & PRODUCTS LIABILITY APPLICATION

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE IS A CLAIMS MADE AND REPORTED POLICY. THIS POLICY APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSURED AND REPORTED IN WRITING TO THE INSURER DURING THE POLICY PERIOD OR THE OPTIONAL EXTENSION PERIOD, IF APPLICABLE. AMOUNTS INCURRED AS CLAIMS EXPENSES SHALL REDUCE AND MAY EXHAUST THE LIMIT OF LIABILITY AND ARE SUBJECT TO THE DEDUCTIBLE. PLEASE READ THIS POLICY CAREFULLY.

BROKER SECTION:

Agency: _____ **Phone** _____

Broker/Agent: _____ **Email:** _____

BACKGROUND INFORMATION – PLEASE READ:

1. Please type or print clearly.
2. Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, please attach a separate page.
4. This application must be completed, dated and signed by a Principal of the Applicant.

I. APPLICANT INFORMATION

a) Name of Applicant (s) (and list all subsidiary Companies) : _____

b) Mailing Address: _____

c) Location(s): _____

d) Telephone _____ Website _____

e) Email _____ Contact Name _____

f) Applicant is: Individual Partnership Corporation Joint Venture LLC

Other: _____

g) Date of Incorporation/Start of Operations: _____

h) Applicant(s) operations (please check all that apply):

Manufacturer		Wholesale/Distributor	
Importer		Exporter	
Manufacturers Rep		Retail	
Other			

i) Gross Sales:

Hardware/Components

E-Liquids

a. Projected Next 12 months: USD _____ USD _____
b. This Year/YTD: USD _____ USD _____
c. Last year: USD _____ USD _____

j) Any Foreign Sales? Yes No If yes, list countries? _____

k) Are you a member of the SFATA.org? Yes No

II. HARDWARE/COMPONENTS

a) What products do you Manufacture (M), Sell (S) or distribute (D):

Product Type	M	S	D
E-Cigarettes (Cigalikes)			
E-Liquid Vaporizers			
Batteries and components (such as Coils and wicks)			
Dry Herb/Oil/Wax Vaporizers			
Other (please describe)			

b) If you are selling or distributing only - who are the manufacturers and where are they located?

(All must be listed)

c) Do all of the batteries and chargers you distribute/sell come with CE certification or similar? Yes No

d) Do all of the batteries and chargers you sell have a safety mechanism to prevent overcharging? Yes No

III. E-LIQUIDS

a) What products do you Manufacture (M), Sell (S) or distribute (D):

Product Type	M	S	D
Finished E-Liquids			
Flavorings or Flavoring Extracts			
Propylene Glycol or Vegetable Glycerine			
Liquid Nicotine			
Other (please describe)			

NOTE – mixing of PG/VG, Nicotine and flavourings is considered manufacture of finished e liquids.

b) Are you a member of AEMSA?

Yes No

(If yes – please skip to question d) below. If no – please continue)

i. If the products you sell are not manufactured by you – please confirm the name of supplier and country of origin: _____

ii. If products are manufactured by you:

1. where do you source your flavoring chemicals, PG/VG and Liquid Nicotine? (List Country of origin and Supplier): _____

2. are these ingredients USP (US Pharmacopoeia) grade certified or equivalent? Yes No

3. do you purchase these ingredients in bulk? Yes No

4. if so, do you store appropriately and manage expiry dates Yes No

5. do you receive product safety data sheets with your flavors? Yes No

6. are the flavoring extracts you purchase from a 3rd party supplier made specifically for use within e liquids? Yes No

7. where are e liquids mixed:

Dedicated Clean Room	
Warehouse	
Staff only area in store	
In store or Vape Lounge as required	
Other (please describe)	

iii) **Warranties.**

The applicant understands that no coverage shall be afforded to finished products:

- 1) which are not batch tested by titration to confirm the nicotine content matches the amount declared on the label**
- 2) which are not sold in child proof/ tamper proof containers**
- 3) which do not have warnings (see section V) on the label**

The applicant further understands that, as a requirement of coverage, all manufacturers must sterilise their mixing/testing/extraction equipment using FDA approved chemicals or alcohols or via Autoclave system.

Please confirm your acceptance by signing below:

- c) Does your E-liquid contain Taurine, Caffeine or any Stimulants OTHER than Nicotine? Yes No
 i. If yes please list: _____
- d) Does your e-liquid contain CBD, THC, or other cannabinoids? Yes No
 i. If yes, please list : _____
 ii. What percentage of sales is for Marijuana related products _____

IV. VAPE SHOPS

- a) Are E-liquid flavour combinations mixed by employees only? Yes No
- b) Are the staff appropriately trained on how to handle liquid nicotine and aware of the dangers associated with spillage ? Yes No
- c) Does this location have a hookah lounge or vaping lounge? Yes No
- d) Does this location have any of the following: ☐ Live Music/DJs ☐ Bouncers/Doormen ☐ Liquor Sold/Served ☐ Fresh Food Service

V. WARNINGS

- a) Do you warn your customers about:
- i. Potential Health Issues associated with Inhalation of Nicotine? Yes No
- ii. Explosion risk due to overcharging and charging with incompatible devices (including USB, car adaptors and iphone chargers)? Yes No
- iii. Toxicity of E-Liquid if spilled on skin? Yes No
- b) Do you advise how e liquid should be stored and disposed of? Yes No
- c) Do you promote your products as a smoking cessation device? Yes No

VI. GENERAL INFORMATION

- a) Have any of your products been discontinued or recalled in the past 5 years? Yes No
 i. If yes, explain _____
- b) Are you planning to introduce any new products in the next 12 months? Yes No
 i. If yes, list product(s) _____
- c) Can your products be identified from those of competitors? Yes No

VII. INSURED HISTORY – CLAIMS, LOSSES, INCIDENTS:

- a) Have you had any claims in the past 5 years? Yes No
 If yes, on a separate sheet provide details and attach loss runs
- b) Are you aware of any incident(s) that may result in a claim not reflected in the above question? Yes No

If yes, explain: _____

VIII. COVERAGE HISTORY:

- a) Carrier: _____ Limits: \$ _____ Premium: \$ _____
Rate: \$ _____ Term: _____ Deductible/SIR: \$ _____
- b) Coverage Form: Occurrence Claims Made Retro Date: _____
- c) Has the applicant ever been declined or refused coverage, or had its coverage cancelled or non-renewed? Yes No
- If yes, explain: _____

IX. COVERAGE REQUEST:

- a) Limits of Coverage/Deductibles:

Coverage	Limits Requested	Deductible Requested	Retroactive Date Requested
Products Liability			
General Liability			

- b) Do you require a Blanket Vendors Additional Insured Endorsement? Yes No
- c) Do you require an individual Vendors Additional Insured Endorsement? Yes No
- If yes, provide name, address, and any special wording requested by the vendor/distributor:

- d) Do you require an individual a Landlord/Lessor Additional Insured Endorsement? Yes No
- If yes, provide name, address, and any special wording requested by the landlord/lessor:

I understand and agree this Application and any supplements attached hereto will be relied upon for issuance of any policy. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to all Lloyd's of London participating syndicates, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Furthermore, I understand that the policy applied for will apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown on the certificate of

insurance issued with the policy or certificate on the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy.

I understand this insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

WARNING

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD, AND SUBJECT TO STATE FINES.

THIS APPLICATION MUST BE SIGNED BY APPLICANT WITHIN 30 DAYS OF BINDING. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY

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APPLICANT SIGNATURE		TITLE
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DATE	REQUESTED EFFECTIVE DATE	