



**Conifer
Insurance
Company**

**T.H.C. General Liability
Application**

General Information

Named Insured: _____

DBA: _____

Mailing Address: _____

City, State, Zip Code: _____

Website Address: _____

Contact Name: _____ Contact Phone: _____

Contact Cell: _____ Email Address: _____

Insured Type: Corporation Partnership LLC
 Individual Other: _____

Proposed Policy Term: Effective: _____ Expiration: _____

Underwriting Information

Date business was established: _____

What are the total Sales for the last 12 months (All locations)?: _____

History – All questions must be answered. Failure to disclose proper history could invalidate any and all coverages.

1. Has any application for similar insurance made on behalf of the applicant and/ or any owner, officer, director, employee, manager or managing member thereof of any predecessor, subsidiary, or affiliated organization thereof been declined, cancelled or non-renewed?
 Yes No

2. Has the applicant had any prior liability and/ or property claims in the past five (5) years?
 Yes No If Yes, please attach current loss runs including details.

3. Complete the following for any applicant or any principal, partner, owner, officer, director, manager or managing member of the applicant or any person(s) or organization(s) proposed for this insurance or any predecessor, subsidiary or affiliated organization:
 - a. Have any of the above been convicted of a felony in the last 10 years? Yes No
 If Yes, please provide details: _____

General Liability

Limit : \$1,000,000 per occurrence/ \$1,000,000 aggregate
 \$1,000,000 per occurrence/ \$2,000,000 aggregate

1. Is the applicant or any of the applicant's employees or contracted workers armed with any type of weapon? Yes No
If Yes, are all permits and licensing requirements complied with? Yes No
2. Does the applicant utilize employed or contracted security guard(s)? Yes No
If Yes, please provide the following:
 - a. Number of Guards: _____
 - b. Does the applicant obtain Certificates of Insurance and is the applicant named as an Additional Insurance? Yes No

Product Liability

Limit: \$100,000 per occurrence/ \$100,000 aggregate
 \$300,000 per occurrence/ \$300,000 aggregate

1. List complete description of products manufactured, sold or distributed by the applicant:

2. Do you manufacture the completed product? Yes No
If No, what component parts are purchased by you: _____
3. Will any vendor repackage, re-label or modify your product? Yes No
If Yes, please explain: _____

Hired and Non-Owned Auto

Limit: \$1,000,000 Yes No

1. Do you deliver or transport cannabis living plants or harvested goods? Yes No
2. Are annual MVR reports of all drivers ordered? Yes No
3. Do you allow any fire arms or weapons in the vehicle? Yes No

Property Section

Please attach the appropriate supplement for each location (Dispensary, Grow or Lessor's Risk). All other Non-Cannabis risks please submit an Acord Property application.

_____, an authorized representative of _____ understands and agrees 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 and I agree to release to Conifer Insurance Company, 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.

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.

THIS APPLICATION MUST BE SIGNED BY THE APPLICANT WITHIN 10 DAYS OF BINDING.

SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY.

Authorized Applicant Signature

Date Signed

Title