RIC INSURANCE General Agency

Business Owners Application – Vape Shops/Smoke Shops
(Complete for Each Business Location)

Applicant Name: _____ Phone Number: _____

Business Name: _____

Email Address: _____ Website: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Square Footage: _____

Business operated as: ☐ Corporation ☐ LLC ☐ LLP ☐ Partnership ☐ Individual ☐ Independent Contractor

Gross Receipts: Prior 12 Months: _____ Next 12 Months: _____

Does the location sell Liquor? ☐ Yes ☐ No If Yes, % of Sales: _____

Does this location sell Beer/Wine? ☐ Yes ☐ No If Yes, % of Sales: _____

Does this location mix and/or manufacture any e-liquids? ☐ Yes ☐ No If Yes, % of Sales: _____

Provide your days/hours of operations: _____

_____

List types of items sold: _____

_____

Does this location have a hookah and/or Lounge space*? ☐ Yes ☐ No

***Lounge space is in a retail store for customers to utilize for vaping, smoking and/or recreational purpose**

Does this location have any of the following?

☐ Live Music/DJs ☐ Bouncers/Doormen ☐ Couches ☐ Video/Arcade Games

☐ Liquor Served ☐ Dance Floor ☐ Television ☐ Fresh Food Served/Sold

☐ Pool Table ☐ Other Recreational Equipment: _____

PROPERTY COVERGE

NOTE: MUST INSURE FOR 90% OF THE REPLACEMENT COST

Age of Building: _____ Construction: _____ Number of Stories: _____

If Building is over 20 years old, when were the following updated? (*) Information Required

*Roof: _____ *Plumbing: _____ *Wiring: _____ Sprinklers: ☐ Yes ☐ No

Is there a central Station Burglar Alarm? ☐ Yes ☐ No IF Yes, name of alarm provider? _____

*If yes, is the aforementioned alarm inside of your unit, active, and in your control ☐ Yes ☐ No

NOTE: Theft/ Vandalism is excluded if there is no active Central Station Burglar Alarm monitored by an alarm provider and may still be limited upon use of an alarm

Other Occupancies in building? (Describe) _____

Adjoining Occupancies: LEFT: _____ RIGHT: _____

Approximate distance from fire station: _____ Distance from fire hydrant: _____

Name & Address of Loss Payee: _____

COVERAGES DESIRED

CONTENTS $: _____

TENANT IMPROVEMENTS $: _____

BUILDING (You Own) $: _____

LOSS OF BUSINESS INCOME Amt per Month: _____/# of Months: _____

SIGN $: _____

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CLAIMS/HISTORY

NOTE: All questions MUST be answered. Failure to disclose claims history could invalidate coverage

1. Do you currently have liability insurance coverage? ☐ Yes ☐ No

Insurer	*Policy #:*	*Liability Limits:*	*Premium:*	*Exp. Date:*

2. Do you currently have property insurance coverage? ☐ Yes ☐ No

Insurer	*Policy #:*	*Property Limits:*	*Premium:*	*Exp. Date:*

3. List all property claims in the past 5 years, whether or not insured: **IF NONE, Check here** ☐

4. List liability claims history arising from any business or other professional activity, whether or not insured **IF NONE, Check here** ☐

5. Do you have knowledge of an event, circumstance or occurrence (other than listed in 3.2 above) prior to the effective date of the proposed policy, or do you foresee that a claim may be brought as a result of said event, circumstance or occurrence? ☐ Yes ☐ No

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 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. 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 APPLICANT WITHIN 30 DAYS OF BINDING. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BECO ES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY

APPLICANT SIGNATURE	TITLE
DATE	REQUESTED EFFECTIVE DATE
LIABILITY LIMIT REQUESTED	

Are you required to name any other person or entity as an Additional Insured: ☐ Yes ☒ No

Name & Address: _____

Interest of the additional insured: ☐ Landlord ☐ City or Government Agency ☐ Lessor ☐ Other: _____

Required the following: ☐ Waiver of Subrogation ☐ Primary/ Non-Contributory Wording