



P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641 • 800-548-4301 • www.neee.com

MANAGEMENT LIABILITY CANNABIS BUSINESS APPLICATION

ANSWER ALL QUESTIONS. If not applicable, indicate N/A.

REQUIRED ATTACHMENTS

- Business Plan / Complete Narrative on Operations
- Most Recent Financials including any Proformas (if not included with the Business Plan)
- Capitalization Table
- Organizational Chart
- Executive and Board List

GENERAL INFORMATION

Full name of applicant: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Number of locations: _____

Website: _____

REQUESTED COVERAGE

Available Coverage Section	Limit of Insurance Each Claim	Limit of Insurance Aggregate	Separate or Shared Limits of Insurance	Deductible	Retroactive Date	Prior or Pending Litigation Date
Directors & Officers Liability Coverage						
Employment Practices Liability Coverage						
Fiduciary Liability Coverage						

OPERATIONS

1) Type of enterprise: For Profit Nonprofit

2) Years of Operation: _____

3) Please check what operations the applicant is engaging in:

- | | | |
|---|--|--|
| <input type="checkbox"/> Recreational Marijuana Growing | <input type="checkbox"/> Patient Care/Physicians on Staff | <input type="checkbox"/> Recreational Marijuana Processing |
| <input type="checkbox"/> Medical Marijuana Growing | <input type="checkbox"/> Product Delivery (patients) | <input type="checkbox"/> Medical Marijuana Processing |
| <input type="checkbox"/> Recreational Marijuana Retailing | <input type="checkbox"/> Product Delivery (wholesale) | <input type="checkbox"/> Marijuana Laboratory Testing |
| <input type="checkbox"/> Medical Marijuana Dispensing | <input type="checkbox"/> Industrial Hemp CDB (cannabinoid) Goods Manufacturing | |
| <input type="checkbox"/> Other: _____ | | |

4) Please list all other business/dba names, including subsidiaries for which you are seeking coverage under this policy:

Name of Subsidiary/Entity	Business Type/Operations	% of Ownership	Date Acquired or Created	Private Co. or Nonprofit Org.

5) Please list any other entities and the relationship to the applicant requesting coverage under the policy: _____

FINANCIAL INFORMATION

1. Please provide the following financial information for the Applicant and its Subsidiaries. Information must be based on the most recent audited financials or interim financials if audited financials are not available.

a) Please provide the following Financial Information for the Applicant and its Subsidiaries:

Based on Financial Statements Dated: _____ (Year/Month)

Current Assets \$ _____

Total Assets \$ _____

Current Liabilities \$ _____

Total Liabilities \$ _____

Total Revenue/Income \$ _____

Estimated Revenue next 12 months \$ _____

Net Income Net Loss \$ _____

Cash flow from operations \$ _____

2. Has the applicant raised capital through any offerings, private placements or other in the last 12 months, or anticipating within the next 12 months? If Yes, please provide detail: _____

3. Has the applicant in the past 12 months, or in the next 12 months anticipate any facility or location closings, consolidations or layoffs? Mergers or acquisitions? If Yes, please provide detail: _____

4. Stock Ownership / total number of voting shareholders: _____

Director/Officer Shareholders	% of Voting Shares Owned:	Others owning 10% or more:	% of Voting Shares Owned:

(Please list any additional shareholders on a separate attachment.)

EMPLOYMENT PRACTICES LIABILITY (Complete only if applying for this coverage)

1. Employee Count: Full Time _____ Part Time _____ Independent Contractors _____
- a. Does the Applicant have written employment agreements with all officers? Yes No
 - b. Have the Applicant's managers and/or supervisors attended training and education programs/ seminars on sexual harassment and other types of discrimination within the last 12 months? Yes No
 If Yes, who has attended? _____
 If Yes, who conducts the sessions? _____
 - c. Does the Applicant have its employment policies/procedures reviewed by labor or employment counsel? Yes No
 If Yes, identify the firm and date of last review: _____
 - d. Does the Applicant have a Human Resources or Personnel Department? Yes No
 If No, who handles this function? _____
 - e. Does the Applicant have an employee handbook? Yes No
 If Yes, does the Applicant distribute it to all employees? Yes No
 If Yes, do all employees sign up for its receipt? Yes No
 If Yes, does it expressly state that it is not a contract and that employment is "at will"? Yes No
 - f. Does the Applicant have written procedures for handling employee complaints of discrimination and/or sexual harassment? Yes No
 - g. Does the Applicant require all terminations to be reviewed by:
 The person in charge of human resources? Yes No
 Outside counsel? Yes No
 - h. Does the Applicant maintain a personnel file for each employee? Yes No

FIDUCIARY LIABILITY (Complete only if applying for this coverage)

Full Name of Plan	Total # of Participants	Active Number of Plan Participants	Total Plan Assets	Type of Plan*
			\$	
			\$	
			\$	
			\$	

Defined Contribution = DC; Defined Benefit = DB; Excess Benefit Plan = EB; Welfare Benefit Plan = WB; Employee Stock Ownership Plan = ESOP

1. Is any listed Plan a multiemployer or multiple employer plan? Yes No
 If yes please provide detail and if merger activity is anticipated.

2. Does the Applicant or any Subsidiary utilize a Plan investment manager? Yes No
 If so, what % of Plan assets are managed by the manager as defined by ERISA? _____
3. How often are plan guidelines and goals reviewed and/or amended by the fiduciaries? _____
4. Have any plans been spun-off, merged or terminated in the last two years? Yes No
5. Does the Applicant or any Subsidiary expect any reduction in benefits, cessation of benefits, or increase in costs to the Plan participants as a result of any plan amendment anticipated in the next twelve months? Yes No
 Was any such amendment adopted within the last two years? Yes No

OTHER MATERIAL INFORMATION/LOSS HISTORY

1. During the past five years, has any insurer ever canceled or non-renewed similar insurance with any applicant, or has your insurance been canceled for nonpayment of premium by any insurance or finance company? Yes No
 If Yes, please explain. _____
2. After inquiry with each person as appropriate, in the last five (5) years, have any Directors and Officers claims, or any wrongful termination, discrimination, sexual harassment or any other wrongful employment practices liability claim or suit, including third party claims, or Fiduciary Liability claim ever been made against the Firm or any predecessor firm or any current or former member of the Firm or predecessor firm? Yes No
 If "Yes," how many? _____ Please complete a separate Supplemental Claim Form for each claim or suit and include a currently valued loss run for each claim.

REQUIRED ATTACHMENTS

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FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____
(Must be signed by a Principal, Partner or Officer of the Firm)

FEIN #: _____

Applicant's Signature: _____ Date: _____

Agent/Broker Name: _____