

New Life Agency, Inc. Lloyd's Coverholder

PO Box 5948, Fresno, CA 93755 • Tel (877) 952-5433 (LIFE) • Fax (877) 952-5589

Underwritten by Certain Underwriters at Lloyd's

**APPLICATION REGULATORY BUSINESS INTERRUPTION INSURANCE
THIS APPLICATION IS FOR A CLAIMS MADE INSURANCE POLICY**

APPLICANT'S INSTRUCTIONS:

1. ALL QUESTIONS MUST BE ANSWERED COMPLETELY; PLEASE TYPE OR PRINT CLEARLY; IF ANY QUESTIONS ARE CONSIDERED "NOT APPLICABLE", PLEASE EXPLAIN WHY.
2. CALCULATE THE PREMIUM FROM THE PREMIUM CHART BELOW.
3. SIGN AND DATE (MUST BE WITHIN 45 DAYS PRIOR TO BINDING) AND RETURN THE COMPLETED APPLICATION TO YOUR BROKER WITH YOUR CHECK FOR THE PREMIUM, PLUS STATE TAXES, POLICY ISSUANCE FEE AND ANY APPLICABLE BROKER FEE.

This coverage is premise-specific coverage and only applies to operational premises at locations included in this application, accepted by the underwriters, and included in the Policy. Please complete all information in detail.

1. Name of proposed Named Insured ("Applicant"): _____

2. Address: _____
(Number) (Street)

City: _____ State: _____ Zip Code: _____

Website: _____

Section 1: Operation Questions

3. Total Annual Revenue of all locations or premises to be insured: \$ _____
4. Attach details regarding each location that will be covered under the Policy. All address information must be included in detail, including exact suite information, nature of business for each location, etc.
5. Describe the nature of your business activities: _____
6. Is your business regulated by any public health department or official? Yes No

If the answer is "Yes" to Questions 7 - 13, coverage cannot be bound per the terms and conditions of this program. If you desire an indication outside the program, please provide details for the "Yes" answers.

7. Has your business ever been closed or quarantined, or given notice by any public health department or public health official for any biological, infectious disease event or any other health-related hazard? Yes No
8. Does your business involve itself in any way with biological materials? Yes No
9. If your business serves or sells food to the public, are more than 50% of receipts from sales of seafood? Yes No
10. Does your business provide habitational, overnight lodging or educational services? Yes No
11. Is your business healthcare related? Yes No
12. Has any claim of the type to be covered by this policy been made against the Insured within the past three (3) years? Yes No
13. Are you aware of any circumstance likely to give rise to a claim of the type to be covered by this policy against the Insured at the time of this order? Yes No

The Applicant warrants to the best of its knowledge and belief that the statements set forth herein are true and include all material information. The Applicant further warrants that if the information supplied on this application changes between the date of this application and the inception date of the policy, it will immediately notify New Life Agency, Inc. PO Box 5948, Fresno, CA 93755 of such changes. Signing of this application does not bind the Company to offer nor the Applicant to accept insurance, but it is agreed that this application shall be the basis of the insurance and will be attached and made part of the policy, should a policy be issued.

Signature of Applicant: _____ Title: _____ Date Signed: _____

Authorized signature of a Principal or Officer - Must be signed and dated no more than 45 days prior to binding

*A copy of this application will be attached to the Policy or Certificate and shall be the basis of the contract.
Signature on this form does not bind Underwriters to grant this insurance*

Regulatory Business Interruption Rates are valid through December 31, 2009
\$1,000,000 Limit per location and in the aggregate

TOTAL REVENUE	PER DAY BENEFIT	PREMIUM (per location)
\$1 - \$749,999	\$1,000	\$500
\$750,000 - \$1,249,999	\$3,000	\$500
\$1,250,000 - \$2,499,999	\$5,000	\$500
\$2,500,000 - \$3,749,999	\$10,000	\$900
\$3,750,000 - \$4,999,999	\$15,000	\$1,200
\$5,000,000 - \$6,249,999	\$20,000	\$1,400
\$6,250,000 - \$7,499,999	\$25,000	\$1,500
\$7,500,000 - \$8,749,999	\$30,000	\$1,650
\$8,750,000 - \$9,999,999	\$35,000	\$1,750
\$10,000,000 - \$12,499,999	\$40,000	\$1,800
\$12,500,000 and up	\$50,000	\$2,000

Payment Instructions:

RETURN THE COMPLETED APPLICATION TO YOUR BROKER WITH YOUR CHECK OR CC PAYMENT ONLINE FOR THE PREMIUM, PLUS STATE TAXES, POLICY ISSUANCE FEE AND ANY APPLICABLE BROKER FEE.

Premium: \$ _____

CA Taxes & Fees: \$ _____ (3.225%in addition)

Broker fee: \$ _____ (in addition)

TOTAL PAYMENT \$ _____

NOTICE:

- 1. THE INSURANCE POLICY THAT YOU ARE APPLYING TO PURCHASE IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED “NONADMITTED” OR “SURPLUS LINE” INSURERS.**
- 2. THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT THAT APPLY TO CALIFORNIA LICENSED INSURERS.**
- 3. THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**
- 4. CALIFORNIA MAINTAINS A LIST OF ELIGIBLE SURPLUS LINE INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEB SITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE: www.insurance.ca.gov.**
- 5. FOR ADDITIONAL INFORMATION ABOUT THE INSURER YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR “SURPLUS LINE” BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE, AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: 1-800-927-4357.**
- 6. IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER’S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.”**

Name of Applicant: _____

Title: _____

Date: _____

Signature of Applicant _____

SF 198230.2 73670 00741 D-1 (Effective January 1, 2009)

SURPLUS LINE FORM
(To be completed by company license holder)

THIS MUST BE COMPLETED IN FULL IN ORDER TO ISSUE THE POLICY
INFORMATION REGARDING THE FILING AND PAYMENT OF
SURPLUS LINE TAXES

Name of Applicant _____

Surplus Lines License
Number for this filing _____

License Filing State _____

Name of Individual
or Company License Holder _____

Address of License Holder _____

Signature of Person _____

Date _____