

**BENCHMARK MANAGEMENT GROUP, INC.**  
General Agent

**Kuffel, Collimore & Company**  
Agent / Broker  
Phone#: 877-335-1234

## Allied Medical General Application

### DISPENSARIES AND GROWERS

<b>NAME OF BUSINESS:</b> _____			
<b>MAILING ADDRESS:</b> _____			
<b>CITY:</b> _____	<b>STATE:</b> _____	<b>ZIP CODE:</b> _____	
<b>INSPECTION CONTACT-NAME:</b> _____		<b>PHONE#</b> _____	
<b>Type of Enterprise:</b> ___ Corporation ___ Individual ___ Partnership ___ Non-Profit ___ Joint Venture ___ LLC ___ Collective/Co-Op Other: _____			
Gross Annual Receipts (sales) from marijuana estimated for next 12 months: \$ _____			
Gross Annual Receipts (sales) from all other products (edibles', etc.) estimated for next 12 months: \$ _____			
Federal Employers Identification Number (FEIN): _____			
Estimated Payroll for next 12 months: \$ _____			
Full description of services rendered:  _____			
<b>Current Insurance:</b>			
Has applicant had previous insurance for this enterprise? ___ No ___ Yes			
If yes, complete the following:			
<b>General Liability (GL)</b>		<b>Professional Liability</b>	
Current Carrier	_____	Current Carrier	_____
Policy term	_____	Policy Term	_____
Premium	_____	Premium	_____
Deductible	_____	Deductible	_____
Limits	_____	Limits	_____
Occurrence or		Occurrence or	
Claims Made	_____	Claims Made	_____
Has any prior insurance been cancelled or nonrenewed: ___ No ___ Yes ___ N/A			
If yes, please provide full details:  _____			
During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you? ___ No ___ Yes ___ N/A			
Has applicant, or any other person for whom insurance is being requested, aware of any circumstances, which may result in a claim: ___ No ___ Yes ___ N/A			
If yes, provide full details:  _____			

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<b>Staff:</b>	<b>Full Time</b>	<b>Part Time</b>	<b>Contracted/Employed</b>
Administrator's	_____	_____	_____
MD/Physicians	_____	_____	_____
Nurse's	_____	_____	_____
Homemakers/Nurse Aids	_____	_____	_____
Psychologist's	_____	_____	_____
Counselor's	_____	_____	_____
Therapist's	_____	_____	_____
Students or volunteers	_____	_____	_____
Other (specify)	_____	_____	_____

Check the hiring procedures that apply or are performed by this operation.

- |  |                             |                              |
|--|-----------------------------|------------------------------|
| Criminal Background Checks   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Reference Checks   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Questioning of employees in their previous involvement as defendants in professional malpractice litigation. | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Verification of certification or professional licensing.   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Drug, alcohol and sexual abuse screening or testing.   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |

**Schedule of Physicians-on Staff or Contracted:**

<u>Name &amp; Specialty</u>	<u>Board Certified</u>	<u>Board Eligible</u>	<u>Hours/Week Worked</u>	<u>Volunteer Contracted Or Employed</u>	<u>Has Malpractice Insurance</u>
_____	_____	_____	_____	_____	No ___ Yes ___
_____	_____	_____	_____	_____	No ___ Yes ___
_____	_____	_____	_____	_____	No ___ Yes ___

Do you wish physician to be covered under the dispensary's policy? No \_\_\_ Yes \_\_\_  
 If no, do they carry insurance and name you as Additional Insured? No \_\_\_ Yes \_\_\_

**Schedule of Location:** If more than 2 locations, attach a separate sheet with locations

#1 Address: \_\_\_\_\_  
 Type of Building & Square Footage: \_\_\_\_\_  
 Type of Services Provided: \_\_\_\_\_

#2 Address: \_\_\_\_\_  
 Type of Building & Square Footage: \_\_\_\_\_  
 Type of Services Provided: \_\_\_\_\_

**ALLIED MEDICAL-DISPENSARIES AND GROWERS  
SUPPLEMENTAL APPLICATION  
PHONE:877-335-1234**

1. Estimated number of patients for the next 12 months: \_\_\_\_\_  
2. Current number of patients: \_\_\_\_\_  
3. Maximum amount of usable marijuana on the premises any one time: \_\_\_\_\_  
4. How does the dispensary get their medicine? \_\_\_\_\_  
Caregivers(%) \_\_\_\_\_ Vendors/Wholesalers(%) \_\_\_\_\_ Grow themselves(%) \_\_\_\_\_  
5. Maximum number of plants on premises at any one time: \_\_\_\_\_  
6. How much of the inventory is displayed and how is it displayed: \_\_\_\_\_

7. What is the highest level of THC dispensed: \_\_\_\_\_  
8. Describe Owners past experience and/or provide a copy of resume (i.e. previous employment) \_\_\_\_\_

9. Days/Hours of operation: \_\_\_\_\_  
10. Are all employees provided training on security procedures and closing? No \_\_\_ Yes \_\_\_  
If so, by whom: \_\_\_\_\_

11. Does the dispensary:  
Maintain a ledger with the quantity of marijuana dispensed per transaction: No \_\_\_\_\_ Yes \_\_\_\_\_  
Record the type and source of the marijuana dispensed: No \_\_\_\_\_ Yes \_\_\_\_\_  
Record the total amount paid by the patient for goods/services: No \_\_\_\_\_ Yes \_\_\_\_\_  
Record the date and time dispensed: No \_\_\_\_\_ Yes \_\_\_\_\_  
Cross check the patients state I.D. card with a valid photo I.D.: No \_\_\_\_\_ Yes \_\_\_\_\_  
If you answered "NO" to any of the above, please describe below: \_\_\_\_\_

12. What security measures are in place:  
Armed Guard \_\_\_\_\_ Unarmed Guard \_\_\_\_\_ Door Checker/Greeter \_\_\_\_\_  
Are Guards and/or Greeters employees: No \_\_\_\_\_ Yes \_\_\_\_\_  
If no, do they carry insurance and name our insured as Additional Insured \_\_\_\_\_

- Video Cameras (interior) \_\_\_\_\_ Safe/Vault \_\_\_\_\_  
Video Cameras (exterior) \_\_\_\_\_ Gated Windows \_\_\_\_\_  
Central Station Alarm \_\_\_\_\_ Gated Doors \_\_\_\_\_  
Hold-up/Panic Button \_\_\_\_\_ Exterior Lighting \_\_\_\_\_  
Other, please describe: \_\_\_\_\_

13. Are any other products sold: edibles, pipes, equipment, lotions, etc.: No \_\_\_ Yes \_\_\_  
If so, please describe: \_\_\_\_\_  
14. Are any products manufactured, mixed, labeled, or relabeled by the applicant:  
If so, please describe: \_\_\_\_\_  
15. Are any other services provided, please describe: \_\_\_\_\_

Applicants Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# ACORD™ PROPERTY SECTION

PRODUCER Kuffel Collimore & Company House Account 1460 North Farnsworth Avenue Suite #5 Aurora, IL 60505-1680	PHONE (A/C. No. Ext): (630)806-8032	APPLICANT (First Named Insured)
CODE:	SUB CODE:	EFFECTIVE DATE
AGENCY CUSTOMER ID:	EXPIRATION DATE	
FOR COMPANY USE ONLY		

PREMISES INFORMATION		PREMISES #: 1	BUILDING #: 1	STREET ADDRESS:		
SUBJECT OF INSURANCE	AMOUNT	COINS %	VALUATION	CAUSES OF LOSS	INFLATION GUARD %	DEDUCTIBLE
Bus. Personal Property	\$	80	RC	Special		1500
Business Income	\$	50		Special		

ADDITIONAL INFORMATION - BUSINESS INCOME/EXTRA EXPENSE

TYPE OF BUSINESS	ORDINARY PAYROLL
<input checked="" type="checkbox"/> NON MFG	<input type="checkbox"/> EXCL <input checked="" type="checkbox"/> INCL
<input type="checkbox"/> MFG	<input type="checkbox"/> 90 DAYS
<input type="checkbox"/> MINING	<input type="checkbox"/> 180 DAYS
<input type="checkbox"/> % COINS	<input type="checkbox"/> \$

CONSTRUCTION TYPE	DISTANCE TO HYDRANT FT	DISTANCE TO FIRE STAT MI	FIRE DISTRICT/CODE NUMBER	PROT CL	# STORIES	# BASMTS	YR BUILT	TOTAL AREA
BUILDING IMPROVEMENTS	BLDG CODE GRADE	TAX CODE	ROOF TYPE	OTHER OCCUPANCIES				
WIRING, YR:	PLUMBING, YR:	HEATING, YR:	WIND CLASS	HEATING BOILER ON PREMISES?				
OTHER:	<input type="checkbox"/> RESISTIVE	<input type="checkbox"/> SEMI-RESISTIVE	<input type="checkbox"/> OTHER	IF YES, IS INSURANCE PLACED ELSEWHERE?				
RIGHT EXPOSURE & DISTANCE	LEFT EXPOSURE & DISTANCE		REAR EXPOSURE & DISTANCE					
BURGLAR ALARM TYPE	CERTIFICATE #	EXPIRATION DATE	EXTENT	GRADE	CENTRAL STATION			
BURGLAR ALARM INSTALLED AND SERVICED BY					# GUARDS/WATCHMEN	WITH KEYS		
PREMISES FIRE PROTECTION (Sprinklers, Standpipes, CO <sup>2</sup> /Chemical Systems)					% SPRNK	FIRE ALARM MANUFACTURER		
						CLOCK HOURLY		
						CENTRAL STATION		
						LOCAL GONG		

ADDITIONAL INTERESTS

RANK:	NAME AND ADDRESS	EVIDENCE CERTIFICATE	RANK:	NAME AND ADDRESS	EVIDENCE CERTIFICATE
<input type="checkbox"/> LOSS PAYEE		<input type="checkbox"/> POLICY	<input type="checkbox"/> LOSS PAYEE		<input type="checkbox"/> POLICY
<input type="checkbox"/> MORTGAGEE			<input type="checkbox"/> MORTGAGEE		

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**MEDICAL MARIJUANA DISPENSARY  
SUPPLEMENTAL**

Name of Applicant: \_\_\_\_\_

Is the parking lot maintained by the insured? Yes  No

If yes, what is the square footage of the parking lot? \_\_\_\_\_

Does the applicant make deliveries off premises? Yes  No

**Applicant understands that there is no coverage for off premises operations.**

Understood and agreed

Does the applicant advertise the nature of the business on the outside of the building?

Yes  No

The building you occupy is:

Frame  Tilt-up/Concrete block/Joisted-Masonry  Other

Do you occupy the entire building?  Yes  No

If no, are there connecting doors to adjacent units, hallways or interior stairwells?

Yes  No

What type of Security systems are utilized:

- Central Station Alarm  Interior Motion Detectors  Gated Doors  
 Gated Windows  Metal Door  Exterior camera & door intercom  
 Hold-up Button/Panic Button  Security Vestibule/Man-trap  
 Interior Video Cameras

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Do you utilize door Identification Checkers?  Yes  No

Do you utilize greeters?  Yes  No

Do you utilize security guards and/or bouncers?  Yes  No

If yes, are they employees?  Yes  No

If no, do they carry insurance and name applicant as additionally insured?

Yes  No

Are they armed?  Yes  No

Is the applicant or any of the applicant's employees armed with any type of weapon?

Yes  No

How much inventory is displayed to customers?

0 to 5%  6 to 10%  11 to 25%  Greater than 25%

After business hours, is all inventory stored in a locked one ton (2000 lbs.) safe?

Yes  No

After business hours, is all inventory stored in a locked safe with a burglary rating at or above U.S. U.L. TL-30?

Yes  No

Do you have a written plan or manual that describe your businesses security procedures, including what to do in the event of a robbery or other crime?

Yes  No

Are employees instructed to cooperate and obey the robber's instructions and not to resist?

Yes  No

Signature of Applicant: \_\_\_\_\_ Dated: \_\_\_\_\_

Signature of Insurance Broker: \_\_\_\_\_ Dated: \_\_\_\_\_

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**Marijuana Risk Warranty**

**It is hereby agreed and understood that the following warranties apply to this policy and that no coverage will be afforded for theft unless the following items are strictly adhered to:**

- 1) During non-business hours, all stock must be kept in a locked, ½ ton or greater safe which is bolted to the floor or a safe with a TL-15 rating or greater, bolted to the floor. This includes perishable items such as kif, butane hash, cookies, and any preparation of medical marijuana.
- 2) During business hours, all stock not on display will be kept in a locked safe with the same requirements as during non-business hours.
- 3) An operating central station burglar alarm must be in place which has contacts on all windows and doors leading to the outside, stairwells and hallways. Motion detectors must be present in the room in which the safe is kept. This burglar alarm must be turned on and fully operational during non-business hours.
- 4) The insured must keep written records of all purchases of stock, including receipts when available, which includes the date of purchase, type(s) of stock purchased and purchase price. In event of a stock claim, adjustment will be based on documented purchase price.

Signed by the Insured \_\_\_\_\_

Date \_\_\_\_\_

**Kuffel, Collimore & Company**  
**Toll Free # (877) 335-1234**

**Loss Warranty Letter**

During the last three (3) years, we warrant that with respect to do the insurance being applied for:

1. I/We have not sustained a loss,
2. Have not had a claim made against us,
3. Have not been denied coverage or had coverage cancelled by an insurance company,
4. Have no knowledge or a reason to anticipate a claim or loss.

If my business is less than three (3) years old, the above referenced warranty applies to work performed through all my prior business entities whether as an owner or an employee.

I understand that this warranty will be incorporated into the insurance contract.

Date: \_\_\_\_\_

Title: \_\_\_\_\_

\_\_\_\_\_  
Signature of Partner, Office, Principal or Owner

**Warranty: The purpose of this no loss letter is to assist in the underwriting process. Information contained herein is specifically relied upon in determination of insurability. The undersigned, therefore, warrants that the information contained herein is true and accurate to the best of his/her knowledge, information and belief. This no loss letter shall be the basis of any insurance that may be issued and will be a part of such policy. It is understood that any misrepresentation or omission shall constitute grounds for immediate cancellation of coverage and denial of claims, if any. It is further understood that the applicant and or affiliated company is under a continuing obligation to immediately notify his/her underwriter through his/her broker of any material alteration of the information given.**