

Restaurant Recovery Insurance (RRI) Application

Please complete this application in its entirety and answer all questions thoroughly. Any references to “you” and “your” represent the Applicant. This Application must be signed and dated by the Applicant’s principal, partner, officer, or director. If you need more space for your answers, please continue a separate sheet of paper and reference the section and question number.

Applicant’s Detail (Section 1)

- Main name of Applicant’s company to be listed as the Insured Name on the proposed policy:

- Requested additional Insured Name’s to be listed on the proposed policy. Applicant must wholly own or have controlling ownership in these company(ies) or subsidiary(ies) to be listed as an additional Insured Name.

- Applicant’s website address: _____
- How many years has the Applicant been in business? _____
- Applicant’s primary address: _____
- Applicant’s primary risk manager’s contact name, phone number, and email:

Restaurant Operations Detail (Section 2)

- Please list all restaurant and store trade names the Applicant does business under:

- Applicant’s ownership of their restaurant trade names: Franchisor Franchisee Independent
- Applicant’s type of restaurant operations (select all that apply): Fast Food (aka QSR - Quick Service Restaurant) Fast Casual Casual Dining Contemporary Casual (aka upscale casual restaurants) Cafe Pizzeria Fine Dining Bar Coffee & Tea Shop Specialty Drink Store (i.e., smoothies, bubble tea, juices) Destination Restaurant Delicatessen Dessert Store Food Truck Ghost Kitchen (aka virtual restaurant) Other (describe): _____
- Applicant’s ownership type of their locations (select all that apply): Franchisor Franchisee Independent

11. Applicant’s total number of **owned** restaurant locations: _____

(Enter the number of locations by ownership type below)

Corporately Owned (Franchisor)	Franchisee Owned	Independently Owned	Franchised (Not Owned)
# _____	# _____	# _____	# _____

12. Applicant’s owned locations domiciled in:

United States (Enter total #)	State with most locations (Enter State Name)	Outside of United States (Enter total #)
# _____	_____	# _____

13. Applicant’s planned number of new locations to be opened within the next 12 months: _____

Revenue Detail (Section 3)

14. Applicant's Total Annual Revenues (previous year actual and upcoming year anticipated)

Year	Annual Revenues (USD)	Net Income (Profit or Loss)
Upcoming Year Anticipated	\$ _____	\$ _____ <input type="checkbox"/> Profit <input type="checkbox"/> Loss
Last Year Actual	\$ _____	\$ _____ <input type="checkbox"/> Profit <input type="checkbox"/> Loss

15. Applicant's anticipated sales source breakdown for the upcoming year:

Sales Category:	Upcoming Year Anticipated Sales (USD)
Food & nonalcoholic beverage sales to customers who attend an owned location:	\$ _____ <input type="checkbox"/> None
Alcoholic beverage sales to customers who attend an owned location:	\$ _____ <input type="checkbox"/> None
Delivery and takeout sales:	\$ _____ <input type="checkbox"/> None
Catering:	\$ _____ <input type="checkbox"/> None
Private events:	\$ _____ <input type="checkbox"/> None
Franchisor - royalties collected from franchised locations:	\$ _____ <input type="checkbox"/> None
Franchisor - supply or distribution of edible products to franchised locations:	\$ _____ <input type="checkbox"/> None
Management fees to operate non-owned restaurant locations:	\$ _____ <input type="checkbox"/> None
Ghost Kitchen (<i>aka virtual kitchen</i>):	\$ _____ <input type="checkbox"/> None
Food Trucks:	\$ _____ <input type="checkbox"/> None
Online sales of edible products direct to consumers (<i>i.e. gift sets, condiments</i>):	\$ _____ <input type="checkbox"/> None
*Other Retailer Sales (<i>explained in question 16</i>)	\$ _____ <input type="checkbox"/> None
Licensing Fees (<i>i.e. Applicant licenses their trade name/brand name to a third party to sell products using it</i>)	\$ _____ <input type="checkbox"/> None

16. ***Other Retailer Sales** - Does the Applicant manufacture, distribute or handle products that are sold to manufacturers, contract manufacturers, or retailers other than their owned restaurant locations? Yes No
i.e., Popular sauces, condiments, or products sold to Walmart, Target, Kroger, Costco, Whole Foods, or other grocery stores/retailers

17. Applicant's average and largest restaurant/store annual detail:

Detail	Revenue	Net Income	Full-time employees	Part-time employees
Largest restaurant/store:	\$ _____	\$ _____	# _____	# _____
Average restaurant/store:	\$ _____	\$ _____	# _____	# _____

Supply Chain / Third Parties Detail (Section 4)

18. Does 100% of products supplied to the Applicant's owned and franchised restaurant locations come from third party suppliers or distributors? Yes No

18b. Does the Applicant distribute or supply any products or ingredients to restaurant locations? Yes No

19. Please list and detail your top five (5) suppliers and/or distributors of edible and cleaning products.

Supplier or Distributor (Name of company)	Products Supplied (Types of edible or cleaning products)

20. Does the Applicant use any pre-cooked and/or frozen products supplied from a commissary? Yes No

21. Does the Applicant utilize ghost kitchens to fulfill online or phone orders? Yes No

22. Are there any oral or written agreements in place that constrain or bar the Applicant, company, its subsidiaries, or its insurance carrier from seeking redress against any supplier or third party who provides the applicant with products, ingredients, or services? Yes No

23. Does the Applicant have written procedures and quality controls in place in the event spot buying is utilized outside of your normal suppliers or distributors? Yes No

Product and Employee Safety / Regulatory Compliance Detail (Section 5)

24. Is the Applicant in full compliance with all international, federal, state, and local government regulations and requirements as a retailer establishment of food, beverage, and edible products? Yes No

25. Do all your part-time and full-time employees have access to paid sick days? Yes No

25b. Do employees get asked if they are experiencing any reportable symptoms (i.e., jaundice, vomiting, diarrhea...) before coming into work?" Yes No

26. Please mark the appropriate boxes for the safety training that the Applicant requires all employees to participate in:
 Handwashing Equipment Cleaning Sanitation Food Temperatures Cutting Boards Food & Proper Chemical Storage HACCP – Hazard Analysis & Critical Control Points Allergens & Cross Contact Employee Illness & Symptoms Reporting Food preparation processes that require a variance by your local health department

27. How many ANSI (American National Standards Institute) certified food handler safety managers does the Applicant require to be onsite at all locations while business is open?

What training program is utilized: ServSafe Other (which one):

28. Does the Applicant serve any raw or undercooked meats, poultry, seafood, shellfish, or eggs? Yes No

29. Does the applicant have a crisis management plan in the event of workplace violence or active assailants? Yes No

Incident History (Section 6)

30. In the last five (5) years, have you had any of the following incidents? *Please answer all the questions in the chart below:*
For all “Yes” answers, please complete the attached Supplemental Form for each applicable incident.

Incident	Yes or No?	Date	Business Interruption Losses (\$USD)
Received a failing grade on a health inspection	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cited, fined, or closed by a government agency, public health authority, or civil authority	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Foodborne illness incident at a location	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Supplied with contaminated product	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Product extortion or malicious product tampering	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Workplace violence incident	<input type="checkbox"/> Yes <input type="checkbox"/> No		

31. Does the Applicant, its principal(s), partner(s), officer(s), director(s) or manager(s) have knowledge or information of any current situation or circumstance which might lead to a claim under the proposed insurance? Yes No
If “Yes,” please provide full details:

THE UNDERSIGNED, ON BEHALF OF THE APPLICANT AND ANY PROSPECTIVE INSURED, DECLARES TO THE BEST OF THEIR KNOWLEDGE THAT ALL THE STATEMENTS AND ANSWERS SET FORTH HEREIN ARE TRUE AND ACCURATE AND THAT NO INFORMATION HAS BEEN WITHHELD. THE UNDERSIGNED FURTHER AGREES, ON BEHALF OF THE APPLICANT AND ANY PROSPECTIVE INSURED, THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE THE APPLICATION IS EXECUTED AND THE TIME THE PROPOSED INSURANCE POLICY IS BOUND OR COVERAGE COMMENCES, THE INSURED SHALL IMMEDIATELY NOTIFY THE INSURER IN WRITING OF SUCH CHANGES, AND THE INSURER MAY MODIFY OR WITHDRAW ITS PROPOSAL AND/OR AGREEMENTS TO BIND THE INSURANCE.

Name:	Signature:
Position/Title:	Date:

Additional Required Document – Schedule of Restaurant/Store Locations:

In addition to this application please provide an excel spreadsheet of all restaurant/store locations which includes columns for trade name, full address, ownership type, ownership entity name

Optional helpful documents to provide: 1) Income Statement 2) Food Safety & Crisis Management Plans 3) Food Safety Certifications 4) Supply Chain Assessment Procedures



Supplemental Form

1. Discovery date of incident (mm/dd/yyyy):
2. What type of incident took place?
3. Location(s) that the incident occurred at:
4. Main cause of the incident:
5. Please describe the incident in as much detail as possible:
6. Was the local health department involved in this incident? Yes No
7. How many restaurant/store locations were closed or affected because of this incident?
8. How long were the locations closed for?
8a. Are all restaurant locations affected now reopened for business? Yes No
9. Did a supplier initiate a recall or was a supplier at fault in providing you contaminated products? Yes No

10. Please identify the total losses incurred and detail each loss category:

Loss Category	Uninsured Amount (USD)	Insured Amount (USD)
Loss of revenue:		
Loss of net income:		
Recall expenses:		
Rehabilitation expenses:		
Increased cost of working:		
Extortion costs:		
Crisis consultant expenses:		
Other (please identify):		
Other (please identify):		
Total Amount of all losses:		

11. How many days did it take to experience the above detailed total losses?
12. What is the status of this incident? On-going Closed/ Costs are final ***If "On-going," please provide the status:***
13. Please describe what corrective actions have been taken to avoid a reoccurrence of the incident:
14. After this incident took place, did the applicant pass a subsequent health inspection ensuring it was safe to continue or reopen business? Yes No