[Professional Services]

Life Sciences R&D and Services Application

canSURE

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Reset Form

Life Sciences R&D and Services Application

Please complete this application in its entirety, as the responses given are material to the provision of terms. There is space for more details in the Additional Information Section at the end of the application. Coverage may be provided on a claims-made basis.

Named Insured: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Contact: _____ Email: _____ Phone: _____

Web: _____

Section 1: About Your Organization

1. What year was your organization established: _____

2. Are you incorporated? Yes ☐ No ☐

3. Do you expect a material change in your operations in the next 12 months? If Yes, please provide details.* Yes ☐ No ☐

4. Have you operated under another name? If Yes, please provide details.* Yes ☐ No ☐

5. Have you acquired any subsidiaries in the past 5 years? If Yes, please provide details.* Yes ☐ No ☐

6. Have you filed for bankruptcy in the past 10 years? If Yes, please provide details.* Yes ☐ No ☐

7. Has your organization, or any shareholders, directors, officers, partners, or members thereof, been under any investigation for alleged criminal violations relating to your business? If Yes, please provide details.* Yes ☐ No ☐

8. Please list any additional locations not noted above:

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

9. Please list any of your subsidiaries or related entities that are controlled by or control your organization:

Entity Name	Description of Operations	Relationship to Named Insured

10. Please describe all of your operations: _____

Section 2: Revenues

1. Please indicate your gross revenue by the following breakdown:

	Revenue: Previous 12 Months			Forecasted Revenue: Next 12 Months		
	Canada	**U.S.A.**	**Rest of World**	**Canada**	**U.S.A.**	**Rest of World**
Clinical Services						
Consulting						
Laboratory						
Licensing Agreements, Royalties						
Pharmacological Services						
Product Sales						
Research & Development, Milestones						
Other:						

2. Please indicate the countries outside of Canada and the United States of America where you have sales/revenues:

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Section 3: Premises

1. Please indicate your organization's biohazard laboratory rating: _____
2. Do you store hazardous materials at your premises? If Yes, please provide details.* Yes O No O
3. Do you store and dispose of all hazardous materials in compliance with federal and provincial laws and regulations? Yes O No O
4. Do you have any laboratory animals on premises? Yes O No O

Section 4: Your Services

1. Please indicate your revenue by type of service by approximate percentage (%) of gross revenue:

____ Bioequivalence, Bioavailability	____ Equipment Leasing/Rental	____ Protocol Design
____ Biostatistics	____ Genetic Testing	____ Quality Assurance/Control
____ Blood/Plasma/Tissue Banks	____ Information Technology Services	____ Regulatory Consulting/Filing
____ Business Services	____ Lab Services	____ Repair, maintenance, installation
____ Clinical Staff Recruitment/Training	____ Participant Selection/Monitoring	____ Site Management
____ Clinical Investigations/Trials	____ Pharmacodynamics	____ Sperm/Egg Banks
____ Consulting	____ Pharmacokinetics	____ Sterilization
____ Contract Research	____ Pharmacovigilance	____ Other - please specify below:
	____ Preclinical Testing	

2. Do you operate an inpatient facility? Yes O No O
3. Do any of your employees provide direct patient care? Yes O No O
4. If Yes to 2., do these employees carry their own professional liability coverage? Yes O No O
5. Do you always use standard contracts prior to providing services (including change orders)? Yes O No O
6. Have you discontinued any services in the past 5 years? If Yes, please provide details.* Yes O No O
7. Do any of your employees hold positions on an institutional review board or research ethics board? Yes O No O
8. Do you have any financial interest in any of the products of your clients? Yes O No O
9. What is the average dollar value of your contracts? _____
10. What is the average duration of your contracts? _____
11. What is the total number of current contracts you have? _____
12. Have any of your clients ceased payment or requested a refund of fees in the past 3 years? If Yes, please provide details.* Yes O No O
13. Please indicate your largest 3 contracts for the current year:

Type of Customer	Contract Value	Services Provided

Section 5: Staffing

1. Please indicate the number of Full Time Equivalent (FTE) of your salaried staff **(1 FTE = 37.5 hours/week)**:

____ Dieticians/Nutritionists	____ Pharmacists	____ Registered Nurses
____ Licensed Practical Nurses	____ Physicians in Administrative Role	____ Registered Practical Nurse
____ Lab Technicians	____ Physicians in Clinical Role	____ Registered Psychiatric Nurses
____ Nurse Practitioners	____ Psychiatrists	____ X-Ray Technicians
____ Paramedics/EMT/Ambulance Attendants	____ Psychologists	____ All Other

*Please provide further details in the space provided under the Additional Information Section.

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2. Please indicate the number of independent contracted professionals and their professions:

#	*Professional Description*				

3. Please indicate the number of physicians practicing at your facility and their specialty:

#	General Practitioners				

4. Do you assume liability for the individuals noted in 2. above through their employment contract?	Yes	O	No	O
5. Are all staff Physicians and Dentists (not in an admin role) members of their mutual defense organisation (i.e., CMPA, CCPA)?	Yes	O	No	O
6. Do you conduct employment reference checks on all employees and volunteers?	Yes	O	No	O
7. Do you have formal medical staff credentialling program which includes initial credentialling, privilege delineation, and recredentialling?	Yes	O	No	O

Section 6: Regulatory and Risk Management

1. Are you in compliance with all applicable regulatory guidelines?	Yes	O	No	O
2. Have you been cited for any regulatory violations in the past 5 years? If Yes, please provide details.*	Yes	O	No	O
3. Do you have a formal written Quality Control and/or Quality Assurance program(s) in place?	Yes	O	No	O
4. Do you maintain all rights of recourse against your suppliers and/or product manufacturers?	Yes	O	No	O
5. Do you have a Risk Management and Loss Prevention Program in place?	Yes	O	No	O
6. Please provide your current Pharmaceutical Product Establishment License:				
7. Please indicate the last date of inspection by Health Canada.				
8. Do you have procedures for documenting incident reports or complaints?	Yes	O	No	O
9. Do you obtain a certificate of insurance from all suppliers and contractors?	Yes	O	No	O
10. Are all contracts reviewed by Legal or your legal representative?	Yes	O	No	O
11. Do you review all policies and procedures on a regular and ongoing basis?	Yes	O	No	O

Section 7: Claims History

1. Have you ever had a claim against your organisation's insurance policies? If Yes, please provide details including date of loss, amount paid or held in reserve, and description of allegation.*	Yes	O	No	O
2. Are you aware of any incidents or circumstances that could potentially give rise to a claim? If Yes, please provide details.*	Yes	O	No	O

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Section 8: Prior Insurance

1. Have you ever been declined coverage, cancelled or non-renewed for insurance requested in this application? Yes ○ No ○

2. Please provide details of your expiring insurance policy:

Coverage	Insurer	Limit	Aggregate	Deductible	Retroactive Date	Premium
General Liability						
Product Liability						
Errors & Omissions						
Medical Malpractice						
Product Recall						
Clinical Trials Liability						

Section 9: Requested Insurance Coverage

1. Please indicate the coverage limit, aggregate, retroactive date and deductible you are requesting:

Coverage	Limit	Aggregate	Deductible	Retroactive Date
General Liability				
Product Liability				
Errors & Omissions				
Medical Malpractice				
Product Recall				
Clinical Trials Liability				

2. Confirm coverage has been in place continuously from Retroactive Dates requested Yes ○ No ○

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R&D and Services Application Addenda

Please complete the relevant section(s) to your operations.

Addendum: Clinical Trials

1. Please complete this schedule of the current human clinical trials you are involved with:

Product/Protocol Name and Number	Phase	No. of Subjects		Country	Indication/ Disease Tested	Status	Revenue (If Any)
		Current	Total				

2. Are all trials conducted in accordance and registered with appropriate local government authorities?	Yes	O	No	O
3. Are all trials conducted in accordance with Ethics Committee/Research Ethics Board approval?	Yes	O	No	O
4. Are all trials conducted in accordance with I.C.H. guidelines?	Yes	O	No	O
5. Do you recruit your own subjects?	Yes	O	No	O
6. Does the clinical trial include clear informed consent for all potential participants?	Yes	O	No	O
7. Do you give medical advice or operate an inpatient facility as part of the clinical trial?	Yes	O	No	O
8. Have any Adverse Event Reports been filed on any of your products in the past 5 years?	Yes	O	No	O
9. If Yes to 8., was your product associated with death, hospitalisation, or permanent injury?	Yes	O	No	O
10. Please provide the number of Expanded Access/Compassionate Use participants:				
11. Have any Clinical Investigators been cited for regulatory violations in connection with you?	Yes	O	No	O
12. Do your clinical trials involve any of the following: minors, infants, women that are known to be pregnant, birth control, genetic engineering, gene therapy, withdrawn pharmaceuticals, opioids, cannabis, an invasive practice or ethical implications?	Yes	O	No	O
13. Do you assume liability under contract for the product?	Yes	O	No	O
14. Does the contract have hold harmless agreements in place in the favour of your organization?	Yes	O	No	O
15. Did a member of staff or physician practicing at your facility write the clinical trial protocols?	Yes	O	No	O
16. Is the presiding physician a member of the CMPA?	Yes	O	No	O

SUBMIT

NOTICE TO APPLICANT:

Consumer and previous insurer reports containing personal, credit, factual or investigative information about the Applicant may be sought in connection with this Applicant for Insurance or any renewal, extension or variation thereof. All provisions contained in the various forms issued under this contract shall be deemed to be contained in the present Application of Insurance. The policy may be deemed to be void and claims may be denied where:

1) An Applicant for a contract:
   a) Gives false or erroneous information to the prejudice of the insurer, or
   b) Knowingly misrepresents or fails to disclose in the Application any fact required to be stated therein; or
2) The Insured contravenes a term of the Contract or commits a fraud; or
3) The Insured willfully makes a false statement in respect of a claim under the contract.

I CERTIFY THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND ACCURATE, I AM AUTHORIZED TO CONTRACT ON BEHALF OF THE INSURED, AND I APPLY FOR A CONTRACT OF INSURANCE BASED UPON THE TRUTH OF THESE STATEMENTS.

I AM IN AGREEMENT THAT THIS DECLARATION SHALL HEREBY FORM PART OF THE INSURANCE CONTRACT.

Applicant's Signature: Position:

Please print name: Date:

BROKER DECLARATION

How long have you known this Applicant? _____

Is this account new or renewal to you? _____

Have you personally viewed the Applicant's operations? _____

What is the condition of facilities and equipment? _____

What is the applicant's attitude toward risk management and insurance? _____

Do you recommend this Applicant? _____

Broker's Signature: Position:

Please print name: Date:

Additonal Information Section:

Please use this space to provide any additional locations, info from questions above, from the addenda, or anything you feel is material to your operations: