

Lexington Insurance Company

200 State Street
Boston, Massachusetts 02109
(617) 330-1100

APPLICATION FOR LIABILITY INSURANCE CLINICAL TRIALS/INVESTIGATIONS

When filling out this application, all questions must be answered completely. If a question is not applicable to the operations in question, please answer "not applicable" or "N.A." If the answer to a question is none, State "none" or "0". If more space is required to completely answer a question, please attach a separate Sheet of paper and identify the question it responds to. Leave no spaces blank.

If this application is accepted by Lexington. The Insurance will be written on a claims-made basis and will only apply to written claims first made against the Insured during the policy period. No coverage will exist for claims first made against the Insured after the end of the policy period unless the extended discovery period applies. No coverage will exist for any claim, the basis of which is Bodily Injury or Property Damage which occurs prior to the retroactive date shown in the declarations page of the policy.

I. APPLICANT INFORMATION

Please attach an annual report or audited financial statement.

1. Applicant _____

Address _____

Other Applicants (explain relationship) _____

Locations (other than above) _____

Parent Corporation _____

Does any coverage purchased by parent afford coverage to you? Yes No. Explain _____

Identify entities acquired within the last 5 years (entity, date acquired, location, operation) _____

2. Applicant is: Individual Partnership Corporation Joint Venture Other _____

3. How long has applicant been in business? _____

Has the applicant ever engaged in this or similar enterprises under a different name? Explain _____

4. Describe all incurred losses of \$10,000 or more. _____

5. Is the applicant aware of any incidents or circumstances involving or arising out to the applicants' products or operations which is likely to result in a claim against the applicant? ___Yes ___No. If yes, attach details.

6. Does any clinical trials involve vaccines? ___Yes ___No

If yes please name of vaccine and indication for use.

7. Does any clinical trial involve SSRI's or antidepressants? ___Yes ___No

If yes please list name of drug and indication for use.

II COVERAGE INFORMATION

1. What policy period is requested? From _____ To _____

2. What limit of liability does the applicant request? _____

3. What deductible or self insured retention does the applicant request? _____

4. Please provide insurance coverage history.

Year	Carrier	Limit	Deductible/Sir	Premium
Current	_____	_____	_____	_____
20	_____	_____	_____	_____
20	_____	_____	_____	_____
19	_____	_____	_____	_____
19	_____	_____	_____	_____

Current retro date if claims made: _____

5. Has any carrier canceled or non-renewed the application liability insurance? __ Yes __ No. Explain

6. Requested Attachments (please attach copies of the following for the Applicant and, to the extent available, each of its subsidiaries):

- a. Latest annual report or Audited Financials
- b. Copy of Informed Consent
- c. Copy of Protocols for Clinical Trials

Signing this application does not bind the applicant nor the insurer to complete the insurance, but it is agreed that the statements contained in this application shall form the basis on which the policy is issued and the applicant warrants all such statements to be true to the best of its knowledge and belief.

Dated at _____ this _____ Day _____ of _____ 20 _____

Name of applicant _____

Signature of authorized representative _____

Title _____