CHUBB® **Chubb Group of Insurance Companies**
15 Mountain View Rd.
Warren, NJ 07059

APPLICATION FOR LIFE SCIENCES POLICY

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1. Save the document to your local computer.
2. Complete the application by providing your responses in the areas provided; utilize the tab key to move ahead to the next field.
3. If there is not enough space for any particular question, please include the full response in an additional attachment to your application, as you would if you were completing a paper-based application.
4. When you have completed the application, please verify the application for accuracy and completeness before signing the application and forwarding the application to your agent or broker. Do not forward applications directly to Chubb unless you are an agent or broker.
5. If you choose to sign the application with a wet signature, please print the final application, sign the application in ink and forward the application to your agent or broker with any necessary supporting materials.
6. If you apply your signature to this form electronically, you hereby consent and agree that your use of a key pad, mouse or other device to click the "I Agree" button constitutes your signature, acceptance and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand. Further, you agree that the lack of a certification authority or other third party verification will not in any way affect the validity or enforceability of your signature or any resulting contract. You can apply your signature electronically by clicking on the signature field. Once all signatures have been applied, forward the application to your agent or broker via email. Any necessary supporting materials should be sent via email or postal service to your agent or broker.

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IF YOU ANSWERED "YES", THEN DO NOT COMPLETE THIS APPLICATION. YOU MIGHT QUALIFY FOR AN EXCLUSIVE CHUBB PROGRAM THAT REQUIRES A SEPARATE APPLICATION BE COMPLETED.

3. Years in business _____

4. Do you have a parent company? ☐ Yes ☐ No
   If Yes, provide name _____

5. Have you ever operated under another name? ☐ Yes ☐ No
   If Yes, provide details

6. Any acquired subsidiaries in the last 5 years? ☐ Yes ☐ No
   If Yes, please provide entity name and date acquired
   Entity Name: _____
   Date Acquired: _____

7. Who are your top 3 competitors?
   _____
   _____
   _____

8. Have you filed for bankruptcy in the last 7 years? ☐ Yes ☐ No

9. Are any of your shareholders, directors, officers, partners, or members thereof under investigation for any alleged criminal violations related to your business? ☐ Yes ☐ No

10. Are you in compliance with all applicable regulatory guidelines? ☐ Yes ☐ No
(if no, provide details)

11. In the last 3 years, have you been cited for any regulatory violations (such as those contained in a warning letter or 483)? ☐ Yes ☐ No
If yes, has the applicable regulatory authority accepted your response(s) and closed the matter? ☐ Yes ☐ No
(if no, provide details)

12. Please list any third parties you have agreed to name as an insured under your insurance:

Additional Insureds	Explain Relationship To Your Business

13. Mark any items where you have products, studies, or services involving any of these. Include past and future activities.

Diseases:

☐ Hepatitis ☐ HIV ☐ TSE

Classes of Products:

☐ Birth control or fertility ☐ Hormone replacement ☐ SSRIs or SNRIs
☐ Drug-eluting stents ☐ Vaccines ☐ Metal-on-metal hip implats

Specific Products:

☐ Cisapride ☐ Dexfenfluramine ☐ DEHP ☐ DES ☐ Dextropropoxyphene
☐ Ephedra or Ephedrine ☐ Fenfluramine ☐ Fentanyl ☐ Gadolinium ☐ Isotretinoin
☐ Latex gloves ☐ Mercury ☐ Metoclopramide ☐ Phentermine
☐ Propoxyphene ☐ PPA ☐ Silicone (implanted)
☐ Thalidomide ☐ Thimerasol ☐ Troglitazone

14. Total number of employees _____ and R&D Payroll _____

15. Do you have a direct sales force, a contracted sales force, or do you use a multi-level marketing system? ☐ Yes ☐ No

16. Indicate any industry trade association memberships

17. Total projected gross sales for the next year? _____
(Attach separate sheet, if necessary)

U.S. & Canada _____
U.K. & Ireland _____
Continental Europe _____
Australia _____
Asia _____
Latin America _____
Africa _____

18. Previous year gross sales (worldwide)? _____

19. Projected annual prescriptions/units to be sold in the next year? _____

20. Projected number of annual products users in the next year? _____

21. Any products or product ingredients/components imported? ☐ Yes ☐ No
(if yes, note ingredient/component and the country)

22. Projected percentage of sales by area:

Drugs/Biologics: _____ %
Medical Devices: _____ %
Dietary Supplements / Nutritional Products: _____ %
Contract Services: _____ %
Distribution: _____ %
Research: _____ %
Other (please explain): _____ % _____

COVERAGE	LIMIT OF LIABILITY REQUESTED
Products-Completed Operations (including Human Clinical Trials)	
Premises / Operations	
Errors & Omissions	

LOSS HISTORY & POTENTIAL LOSS

1. Any claims not yet reported? ☐ Yes ☐ No
   (if yes, provide details)

2. Indicate any product or service past or present that has been involved with any certified, or attempted, class action or multi-district litigation?

3. Are you aware of any fact, circumstance, or situation which one might reasonably expect could give rise to a claim (or multiple claims) that would fall within the scope of the insurance being requested? ☐ Yes ☐ No
   (if yes, provide details)

The information requested in this Application is for underwriting purposes only and does not constitute notice to the Company under any policy of a Claim or potential Claim.

COVERAGE HISTORY

Policy Period	Primary & Excess Limits	Carriers	Occurrence/Claims Made	Retro Date

1. Do you have any outstanding loss control recommendations with your current carrier? ☐ Yes ☐ No
   (if yes, provide details)

2. Has your insurance ever been canceled or non-renewed by a carrier? ☐ Yes ☐ No
   (if yes, provide details)

3. Are any of your products, clinical trials, or services specifically excluded on your existing policy? ☐ Yes ☐ No
   (if yes, provide details)

4. Have you had concurrent claims made insurance for the insurance you are requesting back to your stated requested retroactive date? ☐ Yes ☐ No

II. PRODUCTS-COMPLETED OPERATIONS (including Human Clinical Trials)

NOTICE: This is an application for a policy that may include a claims made trigger (and for certain accounts, claims made and reported) and that the limit of liability under any policy to be issued in response hereto may include both the indemnity payments for claims and payment of claim and defense expenses, as defined in the policy.

If the limit of liability is reduced by payment of claim and defense expenses, please note that the defense cost provision of this policy stipulates that the limits of liability may be completely exhausted by the cost of legal defense. Any deductible or retention shall apply to investigation expense and defense costs as well as indemnity.

If you are involved in this...	*Then complete these sections...*	*And provide this additional information...*
All companies	10	Five years of loss information Most recent financial data (if private)
Drug/Biologic products in trials	1, 7	Consent forms & protocols for actively sponsored trials
Drug/Biologic products approved	1, 8	
Medical device products in trials	2, 7	Consent forms & protocols for actively sponsored trials
Medical device products approved	2, 8	
Dietary supplements / nutritional products	3	
Contract services	4, 9	Copies of largest & standard contracts
Distribution	5, 8, 9	Copies of largest & standard contracts
Non-profit/independent research	6	

1. DRUGS / BIOLOGICS

A. Mark any items where you have past, present, or planned association with these products:

☐ Known Teratogen ☐ Known Carcinogen
☐ Known Mutagen ☐ Weight loss products
☐ Addictive substances ☐ Highly potent cytotoxin

B. Do you manufacture any active pharmaceutical ingredients? ☐ Yes ☐ No
(*If yes, provide details)*

C. Do you utilize nanotechnology in your product development, delivery, or manufacturing? ☐ Yes ☐ No
(*If yes, provide details)*

D. Do you have any past, present, or planned products that do not have formal FDA approval for marketing (such as products subject to DESI, Prescription Drug Wrap-Up, or OTC drug review)? ☐ Yes ☐ No

2. MEDICAL DEVICES

A. Mark any items where you have past, present, or planned association with products or substances in these areas:

☐ ld therapy
☐ Implantable products
☐ IUD devices
☐ Orthopedic pain management device (e.g. pain pumps)
☐ dia tion-emitting devices

B. Do you utilize nanotechnology in your product development, delivery, or manufacturing? ☐ Yes ☐ No
(If yes, provide details)

3. DIETARY SUPPLEMENTS / NUTRITIONAL PRODUCTS

A. Do any of your products make either health or structure/function claims? ☐ Yes ☐ No
If yes, what are the claims and how are they substantiated?

B. Have any of your products ever fit the definition of a new dietary ingredient? ☐ Yes ☐ No
If so, have pre-market safety reviews been conducted per regulations? ☐ Yes ☐ No

C. Have any of your products ever had an active ingredient that would be defined as a drug by a regulatory agency? ☐ Yes ☐ No
If yes, what are they?

D. Do you sell any weight loss, muscle-building or sexual enhancement products? ☐ Yes ☐ No

E. Are you compliant with the most current regulatory requirements related to manufacturing and adverse event reporting? ☐ Yes ☐ No

F. Do you sell any of your products through a multi-level marketing system? ☐ Yes ☐ No

4. CONTRACT PROFESSIONAL SERVICE

Describe the products or services you provide:

Types of Products	Description of Products	Projected Annual Revenue
Pharmaceutical manufacturing for others		
Medical device manufacturing for others		
R&D / Lab instrument manufacturing		
Software development		

Types of Services	Description of Services	Projected Annual Revenue
Clinical trials		
Consulting		
IRB		
Laboratory		
Pharmacovigilance / Safety Surveillance		
Pre-clinical		
Sales & marketing		

A. Do you currently purchase specific professional liability insurance? ☐ Yes ☐ No
(If yes, indicate type of insurance, limit, and insurer)

Type of insurance _____

Limit _____

Insurer _____

B. How many of your customers represent >10% of your sales? _____

C. Do your customized customer management procedures include the following?

1. Written proposal or request for information in order to determine customer performance expectations ☐ Yes ☐ No ☐ N/A
2. Written contract of specifications of services you will provide, signed by the customer ☐ Yes ☐ No ☐ N/A
3. Contract/statement of work which outlines responsibilities of all parties ☐ Yes ☐ No ☐ N/A
4. Written agreement outlining the scope of the project or services ☐ Yes ☐ No ☐ N/A
5. Interim changes documented with customer sign-off; or Yes ☐ ☐ No ☐ N/A
6. Performance milestones acknowledged and accepted with customer sign-off when achieved ☐ Yes ☐ No ☐ N/A

D. What would be the largest financial and business impact on your customers from a failure of any of your products or services? No disruption

E. Have you discontinued any services in the past 3 years? ☐ Yes ☐ No
(*If yes, please explain)*

F. Do you have any services you will be offering to the market within the next year that are substantially different in scope or end-use than your current services? ☐ Yes ☐ No

G. Do you have formalized client complaint resolution policies and procedures? ☐ Yes ☐ No

H. Describe the type and value of the personal property of others at your facilities?

I. Are any healthcare services performed on your site? ☐ Yes ☐ No

(If yes, please describe)

5. DISTRIBUTION

A. Projected percentage of revenue by area:

_____% APIs _____ % Equipment

_____% Dietary Supplements _____ % Medical devices

_____% Drugs/Biologics _____ % Medical device components/software

_____% Drug/Biologic/Dietary Supp. Ingredients _____ % OTHER (describe): _____

B. What types of business entities do you sell to?

C. Do you utilize a computerized system that manages customer orders including validation, expiration date, flagging abnormal requests and verifying customer contract/order? ☐ Yes ☐ No

D. Describe your inventory management system in terms of track and trace systems. Highlight the distribution chain from suppliers through final customer distribution.

E. What type of entities do you source your product from? If your primary product source is another wholesaler, please describe the product validation process you employ.

F. What is your customer return policy? If you accept returned product, what do you do with returned items?

G. If you are a supplier of components or ingredients, or a distributor of products of others, do you require additional insured status on the product license holder's products liability policy? ☐ Yes ☐ No

Do you require indemnification for damages, including defense costs? ☐ Yes ☐ No

H. Do you sell any medical implants? ☐ Yes ☐ No
(*If yes, describe the products and approximate percentage of your revenues that they represent)*

I. Do you sell any OTC products? ☐ Yes ☐ No
(*If yes, describe the products and approximate percentage of your revenues that they represent)*

6. RESEARCH INSTITUTIONS

A. Projected percentage of revenue by area:

_____% Basic research
_____% Clinical testing
_____% IRB services
_____% Medical product research
_____ % Pre-clinical testing
_____ % Product commercialization
_____ % Product licensing
_____ % OTHER (describe): _____

B. Do you perform any service for third parties? ☐ Yes ☐ No
(*If yes, please explain the services rendered. If no, skip to question 4.)*

C. Do you provide the service as part of an open-ended contract? ☐ Yes ☐ No

D. Do you have any unpaid volunteers or students working in your organizations? ☐ Yes ☐ No
If yes, how many? _____

E. Are any healthcare services performed on your site? ☐ Yes ☐ No
(*If yes, please describe)*

F. What are your top two funding sources?

7. HUMAN CLINICAL TRIALS

Active Trials Currently Being Sponsored. (include phase 4)Sponsored trials (present and planned) for the next year

Product Name & Protocol Number	# of New Subjects to be Enrolled Over Next Policy Period	Indication	Trial Phase	Country(ies)	Countries where local insurance is placed
				United States, Japan,	
				sjaksadjfj aklsdfjlsk;a a	
				ddj faskl dkd s fjkl; d;	
				sdfasdfa fadfas sda ad dfsdfsdfsdf sdf sdf	

A. Number of expanded access/compassionate use subjects anticipated in the coming policy term? _____

B. Total number of human subjects enrolled in the last 3 years: _____

C. Any clinical trials past, present, or planned involving minors? ☐ Yes ☐ No
(*If yes, provide details)*

D. Have there been any clinical trials involving your product which have been discontinued or suspended in whole, or in part, because of safety reasons? ☐ Yes ☐ No
(if yes, provide details)

E. Have any clinical investigators been cited for regulatory violations in connection with your trials (e.g., serious regulatory non-compliance, fraud)? ☐ Yes ☐ No
(If yes, please provide details)

F. Number of clinical trial "For Cause Audits" conducted by you or regulatory agency in the last 5 years? _____
(Please provide details)

G. Do you provide Clinical Investigators, CROs or Sites with compensation other than charges for specific services rendered (e.g., enrollment bonuses, equity interest)? ☐ Yes ☐ No

H. What is the targeted reading grade level for your informed consent documents? _____

I. Do you require Clinical Investigators to test participants on their understanding of the informed consent document? ☐ Yes ☐ No

J. Do you incorporate financial disclosures in the informed consent documents or process? ☐ Yes ☐ No

K. What has been the maximum compensation you have offered trial participants? _____

L. Do you have formalized Clinical Trial Suspension SOPs in place? ☐ Yes ☐ No

M. Do you ever act as both trial sponsor and clinical investigator? ☐ Yes ☐ No

N. Do you ever provide material or product for investigator-sponsored trials? ☐ Yes ☐ No

O. Do you operate an in-patient facility? Yes ☐ ☐ No
If so, do you have an accredited emergency care facility? ☐ Yes ☐ No

P. Do you ever provide material or product for another organization's clinical study/trial? ☐ Yes ☐ No

Q. Do you publish all clinical trial results? Yes ☐ ☐ No

8. REGULATORY

A. Any products manufactured or sold under others' labels? ☐ Yes ☐ No
(if yes, provide details)

B. Any products sold as ingredients/components for other products? ☐ Yes ☐ No
(if yes, provide details)

C. Any products approved for use by minors? ☐ Yes ☐ No
(if yes, provide details)

D. Any products discontinued for safety reasons? ☐ Yes ☐ No
(if yes, provide details)

E. Any association with banned products? ☐ Yes ☐ No
(if yes, provide details)

F. How many product recalls have you had in the past 3 years? _____
Describe in detail any Class 1 recalls.

G. Indicate the top 3 products in terms of number of Adverse Event Reports where the product was associated with a death, permanent injury, or hospitalization outcome? Please provide copy of most recently completed Safety Report associated with these products.

H. Identify any product requiring the addition of a black box or other significant safety warning to existing labeling or instruction manuals in the last 3 years.

I. Identify any product requiring a Risk Evaluation & Mitigation Strategy (REMS).

J. Are there any safety surveillance team recommendations involving any of the following forms of remedial actions, which have yet to be implemented or completed?

"Healthcare Professional" letter; ☐ Yes ☐ No

additional studies; or ☐ Yes ☐ No

expanded product monitoring ☐ Yes ☐ No

K. What, if any, steps would be taken if you became aware of a pervasive off-label use of your products?

L. Do you allow any off-label information dissemination? ☐ Yes ☐ No
If yes, under what conditions?

M. Do compliance audits include follow-up discussions with physicians? ☐ Yes ☐ No

N. Do you do any direct-to-consumer ("DTC") advertising? ☐ Yes ☐ No

O. Is there a required waiting period after product launch before DTC is conducted? ☐ Yes ☐ No

P. Do you have a written policy prohibiting physician incentives? ☐ Yes ☐ No

Q. Have there been any incidents of non-compliance regarding regulations concerning sales and marketing practices by either internal or external product sales personnel? ☐ Yes ☐ No

R. Do you have a formal policy specifically prohibiting physical patient contact by internal and external product sales personnel? ☐ Yes ☐ No

Have there been any incidents of non-compliance in the last 3 years? ☐ Yes ☐ No
(If yes, please describe)

S. How often is formal and documented compliance training required of your internal and external sales force?

T. How do you track and trace your product?

9. CONTRACTS

A. Do you use a written contract or agreement with all clients, subcontractors, and suppliers? ☐ Yes ☐ No

B. Do you have stated minimum contract standards pertaining to your products or your services? ☐ Yes ☐ No

C. Do your global contracts or agreements comply with stated minimum standards? ☐ Yes ☐ No

D. Do all of your contracts include a mutual hold harmless clause? ☐ Yes ☐ No

E. Do you ever assume the tort liability of another party? ☐ Yes ☐ No
(If yes, please explain)

F. What is the value of your average performance-based contract, P.O. or agreement? _____

G. What is the duration of your average performance-based contract, P.O. or agreement? _____

H. Do you accept customized contracts, P.O.s or agreements? ☐ Yes ☐ No

If yes, does legal counsel or senior management review all such documents prior to mutual assent? ☐ Yes ☐ No

I. In the last three years, have you been involved in any contract disputes or have any contracts past due acceptance? ☐ Yes ☐ No
(Please explain)

J. Do you have a formal, written records retention policy? ☐ Yes ☐ No

K. How often do you agree to name third parties as additional insureds under your policy? _____
Under what circumstances, do you agree to this?

L. Provide the following information for your five largest contracts, purchase orders or agreements:

Customer	Contract Amount	Product or Service	Duration

10. HEALTHCARE PROFESSIONAL STAFF

Health professionals	Specialty	# Applicant Employees	# Independent Contractors	Est. # hours of direct patient care annually	Est. % of time providing direct patient care annually
Physicians					
RN's Nurse					
LPN's Phlebotomist					
Pharmacist					
Medical/Lab Technician					
EMT/Paramedic's					
Others (please describe)					
Details:					

A. Does your organization carry medical malpractice insurance for claims arising out of the acts of your employees? ☐ Yes ☐ No
If so, who is the carrier and what is the limit of insurance provided?
Carrier: _____
Limit of Insurance: _____

B. Do you require that all employees and independent contractors who have direct patient interaction carry medical malpractice insurance? ☐ Yes ☐ No
If so, what are the limits of insurance required? _____
Do you obtain evidence of coverage on an annual basis? ☐ Yes ☐ No
Details:

III. PREMISES / OPERATIONS

1. Indicate which of the following applies to your premises:
   a. access is not allowed without card and/or authorized employee ☐ Yes ☐ No
   b. front desk registration only Yes ☐ ☐ No
   c. no restricted access. Ye ☐ s ☐ No

2. Indicate how many gallons of hazardous substances are kept on site? _____

3. Which of the following apply to the storage of hazardous substances on site?
   a. outdoor storage Yes ☐ ☐ No ☐ NA
   b. indoor cut-off area in approved containers ☐ Yes ☐ No ☐ NA
   c. indoor cut-off area in unapproved containers just-in-time supply levels ☐ Yes ☐ No ☐ NA
   d just-in-time supply Yes ☐ ☐ No ☐ NA

4. Are you in compliance with Hazardous Materials Regulations? ☐ Yes ☐ No ☐ NA

5. Highest Biohazard Lab rating? _____

6. Do you have an animal facility or house animals? ☐ Yes ☐ No

7. What are the main focal areas of your Enterprise Risk/Safety Program?
   (Areas might include Regulatory Compliance, Company practices that foster "Best in Class" product, worker and facility risk mitigation efforts (e.g., Code of Conduct), Privacy, Biohazard Management, Disaster Recovery Program)

8. Do you require that all new employees participate in training that instructs them on all applicable company policies and procedures? ☐ Yes ☐ No

9. Do you require Certificates of Insurance from all of your suppliers and sub-contractors? ☐ Yes ☐ No
   What limits and terms do you require?

10. How often are the risk management programs and SOP's audited annually? _____

11. Please indicate any risk management programs and SOPs that are audited by independent non-governmental organizations/individuals?

12. Do you have a formalized information security policy that dictates the protocols that control access to or use of all critical data, processes or information systems for all authorized users, including business partners and third parties? ☐ Yes ☐ No

13. Do you have an information security officer? ☐ Yes ☐ No

14. Do you have a formalized Privacy Policy in place? ☐ Yes ☐ No
    If yes, when was it last updated and audited? _____

15. Do you have a crisis management team in place? ☐ Yes ☐ No

IV. ERRORS & OMISSIONS LIABILITY

NOTICE: This is an application for a policy that may include a claims made trigger (and for certain accounts, claims made and reported) and that the limit of liability under any policy to be issued in response hereto may include both the indemnity payments for claims and payment of claim and defense expenses, as defined in the policy.

If the limit of liability is reduced by payment of claim and defense expenses, please note that the defense cost provision of this policy stipulates that the limits of liability may be completely exhausted by the cost of legal defense. Any deductible or retention shall apply to investigation expense and defense costs as well as indemnity.

1. TYPES OF PRODUCTS & SERVICES, INDUSTRIES SERVED, REVENUE

IF YOU HAVE COMPLETED THE CONTRACT SERVICES SECTION OF THE PRODUCTS-COMPLETED OPERATIONS APPLICATION, THEN SKIP THIS SECTION AND GO TO SECTION 2 "CONTRACTS" BELOW.

Types of Products	Description of Products	Projected Annual Revenue
Pharmaceutical manufacturing for others		
Medical device manufacturing for others		
R&D / Lab instrument manufacturing		
Software development		

Types of Services	Description of Services	Projected Annual Revenue
Clinical trials		
IRB		
Laboratory		
Pre-clinical		
Sales & marketing		
Pharmacovigilance / Safety Surveillance		
Consulting		

A. Do you currently purchase any healthcare professional liability or other professional liability insurance? ☐ Yes ☐ No

If Yes, provide the following:

Type of Insurance Purchased _____

Limits of Insurance _____

Effective Date _____

Carrier _____

B. How many distinct products or services do you offer? ☐ 1-3 ☐ 4-6 ☐ More than 6

C. How many of your customers represent 10 percent or more of your total revenue? ☐ 0 ☐ 1 ☐ 2 ☐ 3

D. Please provide more detailed information about these customers:

Customer	Revenue	Product or Service

E. What would be the largest financial and business impact on your customers from a failure of any of your products or services? No disruption

F. Have you discontinued any products or services in the past three years? ☐ Yes ☐ No
If yes, do you continue to provide service or maintenance? ☐ Yes ☐ No

G. Do you have any products or services entering the market within the next year that are substantially different in scope or end use than your current products or services? ☐ Yes ☐ No

H. Do you have a process to evaluate the financial conditions of your customers and suppliers? ☐ Yes ☐ No

2. CONTRACTS

IF YOU HAVE COMPLETED THE CONTRACTS SECTION OF THE PRODUCTS-COMPLETED OPERATIONS APPLICATION, THEN SKIP THIS SECTION AND GO TO SECTION 3 "QUALITY CONTROL" BELOW.

A. Do you have stated minimum contract standards pertaining to your products or your services? ☐ Yes ☐ No

B. Do your global contracts or agreements comply with stated minimum standards? ☐ Yes ☐ No

C. Do you accept customized contracts, purchase orders or agreements? ☐ Yes ☐ No
If Yes, does legal counsel or senior management review all such contracts, purchase orders or agreements prior to mutual assent? ☐ Yes ☐ No

D. What is the average value of your average performance-based contract, purchase order or agreement? <50K

E. Does the value of any performance-based contract, purchase order or agreement exceed $2.5M? ☐ Yes ☐ No

F. What is the duration of your average performance-based contract, purchase order or agreement? >12 months

G. Provide the following information for your five largest contracts, purchase orders or agreements:

Customer	Contract Amount	Product or Service	Duration

3. QUALITY CONTROL

A. Do your quality-control procedures include the following?

- Written and formalized quality-control program ☐ Yes ☐ No ☐ N/A
- Alpha testing Yes ☐ ☐ No ☐ N/A
- Beta testing Yes ☐ ☐ No ☐ N/A
- Formal customer-acceptance procedure Yes ☐ ☐ No ☐ N/A
- Systems-development methodology in writing ☐ Yes ☐ No ☐ N/A
- Formal product-recall plan Yes ☐ ☐ No ☐ N/A
- Formal policy for documenting and responding to customer complaints or requests for changes or fixes ☐ Yes ☐ No ☐ N/A

B. Do your products/services comply with any accepted industry standards? _____

C. Do your customized customer-management procedures include the following?

1. A written proposal or request for information in order to determine customer performance expectations ☐ Yes ☐ No ☐ N/A
2. A written contract of specifications of products and services you will provide, signed by the customer ☐ Yes ☐ No ☐ N/A
3. Contract/statement of work which outlines responsibilities of all parties ☐ Yes ☐ No ☐ N/A
4. A written agreement outlining the scope of the project or services ☐ Yes ☐ No ☐ N/A
5. Interim changes documented with customer sign-off ☐ Yes ☐ No ☐ N/A
6. Performance milestones acknowledged and accepted with customer sign-off when achieved ☐ Yes ☐ No ☐ N/A

D. Does your information-security officer or development QC manager have responsibility for ensuring that all products are continually evaluated throughout their life cycle for known security vulnerabilities? ☐ Yes ☐ No ☐ N/A

E. Do you have a document-retention policy? ☐ Yes ☐ No ☐ N/A

4. CUSTOMER SUPPORT

A. Do you have at least two forms of customer or product support? ☐ Yes ☐ No ☐ N/A

B. Describe your customer training and support:
Is there customer support 24 hours a day? ☐ Yes ☐ No
Do you maintain written logs for customer complaints of problems or downtime? ☐ Yes ☐ No
How long are they retained? (number of whole or partial months) _____

C. Do you inform customers of problems you discover? ☐ Yes ☐ No

D. Describe your escalation procedure for customer or product-support complaints or issues that are not easily resolved:

5. HISTORICAL INFORMATION

In the past five (5) years, have you been sued or threatened with suit for any act, error or omission relating to your products or services? ☐ Yes ☐ No

In the past five (5) years, have any of your products or services been recalled from use? ☐ Yes ☐ No

In the past five (5) years, has there been any current or past administrative, civil or criminal investigation or litigation by any governmental or regulatory authority? ☐ Yes ☐ No

Are you aware of any act, error or omission, unresolved contract dispute, or any other circumstance that may reasonably be expected to result in a claim or suit to which this insurance applies? ☐ Yes ☐ No

V. WORKERS' COMPENSATION

Answers to these industry-specific questions are requested as a supplement to standard industry (e.g. Acord) Workers' Compensation application.

1. How many of your employees currently (or will, in the next year) work with compounds known to be teratogens, mutagens, or carcinogens? _____

2. How many of your employees currently (or will, in the next year) work with nano-materials (including, but not limited to, carbon nanotubes, buckyballs, fullerenes, nano-scale gold, nano-scale silver, nano-scale oxides, nano-scale liposomes)? _____

3. How many of your employees currently (or will, in the next year) work with materials or equipment emitting ionizing radiation? _____

4. Do you have any employees who currently (or will, in the next year) work with blood, body fluids, or tissue samples that are known to contain human pathogens or animal pathogens known to infect humans? ☐ Yes ☐ No
   If Yes, go to 5. If No, go to 6.

5. Fill in the number of your employees who currently (or will, in the next year) work with materials requiring specific biohazard safety controls.
   BSL 1 _____
   BSL 2 _____
   BLS 3 _____
   BLS 4 _____

6. Do you have any contracts with U.S. government agencies where Defense Base Act coverage is required? ☐ Yes ☐ No

VI. SIGNATURE / CERTIFICATION

NOTICE TO APPLICANT - PLEASE READ CAREFULLY.

INFORMATION OR DATA CONTAINED IN OR SUBMITTED IN CONNECTION WITH THIS APPLICATION (OR OTHERWISE TO ANY OF THE MEMBER INSURERS OF CHUBB GROUP OF INSURANCE COMPANIES ("CHUBB") IN CONNECTION WITH THE UNDERWRITING PROCESS) DOES NOT CONSTITUTE NOTICE OF AN OCCURRENCE, WRONGFUL ACT, CLAIM, SUIT OR OTHER CIRCUMSTANCE AND DOES NOT SATISFY ANY OF THE REPORTING NOTIFICATION OR OTHER PROVISIONS OF ANY POLICY. ALL SUCH NOTICES MUST BE GIVEN SEPARATELY IN ACCORDANCE WITH THE APPLICABLE POLICY CONDITIONS.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES, INCLUDING BUT NOT LIMITED TO FINES, DENIAL OF INSURANCE BENEFITS, CIVIL DAMAGES, CRIMINAL PROSECUTION AND CONFINEMENT IN STATE PRISON.

COMPLETION OF THIS APPLICATION DOES NOT BIND INSURANCE. APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING INSURANCE AND POLICY ISSUANCE.

CERTIFICATION

For the purposes of this application, the undersigned declares and acknowledges by clicking where indicated below that, he/she has reviewed this application and the statements contained therein with his/her Chief Executive Officer, Chief Financial Officer, Chief Operating Officer or their equivalents, and that to the best of their knowledge and belief, after reasonable inquiry, the statements in this application, and in any attachments, are true and complete.

Chubb is authorized to make any inquiry in connection with this application. Signing this application shall not constitute a binder or obligate Chubb to complete this insurance, but it is agreed this application shall be the basis upon which a policy may be issued.

If the statements in this application or in any attachment change materially before the effective date of any proposed policy, the applicant must notify Chubb, and Chubb may modify or withdraw any quotation.

You understand that the limit of liability under any policy to be issued in response hereto shall include both indemnity payments for claims and payment of claim and defense expenses, as defined in the policy.

The undersigned persons understand and further agree that the completion and signing of this APPLICATION neither binds Chubb to sell nor the Applicant to purchase the insurance.

PLEASE NOTE: ONLY DULY APPOINTED AGENTS OF CHUBB AND LICENSED BROKERS ARE AUTHORIZED TO SOLICIT APPLICATIONS FOR INSURANCE. AGENTS AND BROKERS ARE NOT AUTHORIZED TO BIND INSURANCE. NO INSURANCE SHALL BE PROVIDED UNLESS CHUBB ACCEPTS THE APPLICATION AND BINDS THE INSURANCE.

By signing below, applicant hereby certifies that the statements made and the information and data supplied herewith are true, accurate and complete.

Authorized Signature of Applicant	*Date*	
Print Name	*Title*	
Applicant	Authorized Agent *(Please Print Name)*	
Authorized Agent *(Signature)*	Title	Date
Submitted By *(Insurance Agent)*	Insurance Agency	
Agent License No. *(For non-admitted placements a copy of valid surplus lines license will be required)*		
Address *(No., Street, City, State, and ZIP Code)*		

NOTICE TO APPLICANT - PLEASE READ CAREFULLY.
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES, INCLUDING BUT NOT LIMITED TO FINES, DENIAL OF INSURANCE BENEFITS, CIVIL DAMAGES, CRIMINAL PROSECUTION AND CONFINEMENT IN STATE PRISON.
APPLICABLE IN:

ARKANSAS
ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

COLORADO
IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

DISTRICT OF COLUMBIA
WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

FLORIDA
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

KENTUCKY
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

LOUISIANA
ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAINE
IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

MARYLAND
ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NEW JERSEY
ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NEW MEXICO
ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NEW YORK
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

OHIO
ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

OKLAHOMA
WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

OREGON
ANY PERSON, WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY MATERIAL FACT THERETO, MAY BE GUILTY OF AN INSURANCE FRAUD.

PENNSYLVANIA

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

TENNESSEE, VIRGINIA AND WASHINGTON

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

RHODE ISLAND AND WEST VIRGINIA

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

This is an application for a policy that may be issued in a state that requires us to advise you that if available, the following condition is added to your policy: All references in the policy to "spouse" include a party to a civil union or domestic partnership recognized under the applicable law of the jurisdiction having authority.