Life Sciences 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: _____

Section 1: About Your Organization

1. What year was the organization established: _____

2. Is your organization incorporated? Yes O No O

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

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

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

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

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 O No O

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**
Manufacturing and Sale of Own Product						
Manufacturing is Contracted Out for Own Product						
Contract Manufacturing for Third Parties						
Wholesale/Distribution of Third Party's Products						
Repackaging or Relabelling of Wholesale Products						
Retail Sales						
Licensing Agreements, Royalties						
Research & Development, Milestones						
Consulting for a Fee						
Other:						

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

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

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
5. Do you have any personal property of others in your care, custody or control? If Yes, please provide details.*	Yes O	No O

Section 4: Your Products

1. Please list your 10 top-selling products by approximate percentage (%) of gross revenue:

%	*Your Product*				

2. Please indicate your sales by type by approximate percentage (%) of gross revenue:

	Blood and Blood Components		Generic Pharmaceuticals		Proprietary Biologics
	Components, Fine Chemicals, APIs		Imaging, Diagnostic Agents		Proprietary Pharmaceuticals
	Controlled Drugs		Infusions		Radiopharmaceuticals
	Cosmetics		Nutraceuticals, Natural Health Products		Vaccines
	Dietary Supplements, Vitamins				Veterinary
	Drug Delivery		Over-the-Counter Biologics		Other, please indicate below:
	Generic Biologics		Over-the-Counter Pharmaceuticals		

3. If your sales include Pharmaceuticals or Biologics, please indicate by appropriate Anatomical Main Group by approximate percentage (%) of gross revenue of these sales:

	Alimentary Tract and Metabolism		Blood and Blood-Forming Organs		Nervous System
	Anti-Infectives for Systemic Use		Cardiovascular System		Respiratory System
	Antineoplastic and Immunomodulating Agents		Dermatological		Sensory Organs
			Genito Urinary System		Sex Hormones
	Antiparasitic Products, Insecticides and Repellents		Musculo-Skeletal System		Systemic Hormonal Preparations

4. Have any of your products been on the market for less than 3 years? If Yes, please provide details.*	Yes O	No O
5. Have any of your products been recalled or withdrawn in the past 5 years? If Yes, please provide details.*	Yes O	No O
6. Have any Adverse Event Reports been filed on any of your products in the past 5 years?	Yes O	No O
7. If Yes to 6., was your product associated with death, hospitalisation, or permanent injury?	Yes O	No O
8. Do any of your products come with a Black Box or other significant safety warning? If Yes, please identify which products.*	Yes O	No O
9. Are any of your products sold under third-party labels or as a component(s) of others' products? If Yes, please provide details.*	Yes O	No O
10. Do you and your suppliers use Canadian-approved chemicals and ingredients as per Controlled Drugs and Substances Act, Canadian Food and Drug Act, and Natural Health Products Regulations?	Yes O	No O
11. Are all of the products you sell approved by Health Canada, the Federal Drug Agency, and/or the relevant local governing body?	Yes O	No O
12. Do you intend to bring any new product(s) to market in the next 12 months? If Yes, please provide details.*	Yes O	No O
13. Do you provide any type of clinical services as part of your operations? If Yes, please provide details.*	Yes O	No O
14. Do any of your staff interact directly with end users/consumers? If Yes, please provide details.*	Yes O	No O

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

Section 5: Specific Products/Ingredients

1. Please indicate if you are involved with any of the following **products or their derivatives**. Please note that some of the products below may be excluded in the insurance policy, but coverage may be extended in some circumstances: Yes ☐ No ☐

1,3-dimetheylamylamine (DMAA)	Canthaxanthin	Fibrates	Opioids
	Cascara Segrada	Formaldehyde and Acetaldehyde	Pennyroyal Oil
4-Amino-2-Methylpentane Citrate	Chaparral		Phenylpropanolamine (PPA)
	Chromium Picolinate	Gamma Hydroxybutyric Acid (GHB)	Primodos, Amenorone Forte;
5-HTP	Cisapride		Pyrrolizidine Alkaloids (PAs)
Aegeline or N-(2-hydroxy-2(4-methoxyphenyl)ethyl)-3-phenyl-2-propenamide	Comfrey	Gamma-Butyrolactone (GBL)	Psychostimulants, Nootropics
	Contraceptives, including Birth Control Pills	Germanium	Retinoic acid (or its salts), Tretinoin, Isotretinoin
		Germander	
AMP Citrate/DMBA	Cox-2 Inhibitors;	Glandular Extracts	Risperidone
Anabolic Steroids	Danthron	Hormonal Contraceptives	Selective Serotonin Reuptake Inhibitors (SSRIs) and Serotonin -Norepinephrine Reuptake Inhibitors (SNRIs)
Androgens	Debendox	Hydroquinone	
Angiotensin II Receptor Blockers	Di-(2-ethylhexyl) Phthalate (DEHP)	Hypnotics	
Antipsychotics		Jun Bu Huan	
Anxiolytics	Diethylstilbesterol (DES)	Kava, kava-kava (Piper Methysticum);	Serotonin (5HT3) Antagonists
Aprotinin (Bovine Pancreatic Trypsin Inhibitor)	Dioxins		Synephrine
	DMAA (1,3-dimethylamylamine), 1,4 DMAA, dimethyl amylamine;	Kraton (Mitragyna Speciosa)	Talcum Powder
Aphrodisiacs		Latex	Thalidomide
Aprotinin		Lobelia	Thiazolidinediones
Aristolochic Acid	DMHA, Dimethylhexylamine;	Leflunomide	Thimerosal, Thiomersal
Benzene	Docetaxel	Mercury	Tiratricol (3, 5, 3-triodothyroacetic acid)
Bextra	Ephedra, Ephedrine, pseudoephedrine (not used in Rx or OTC cough/cold medicine)	Methylhexanamine, Forthane, Geranamine;	
Bismacine/Chromacine			Trix Metabolic Accelerator
Bisphosphonates		Methylphenidate	Vioxx
Borage Containing PAs	Estrogens	Metoclopramide	Yohimbe
Bupropion	Fenfluramine		
Butanediol	Fertility Drugs and/or Products		

2. If you have indicated Yes to 1., please indicate what product(s) or their derivative(s) are included in your products:

Section 6: Regulatory and Risk Management

1. Are you in compliance with all applicable regulatory guidelines? Yes ☐ No ☐
2. Have you been cited for any regulatory violations in the past 5 years? If Yes, please provide details.* Yes ☐ No ☐
3. Do you follow Good Manufacturing Practices (GMP)? Yes ☐ No ☐
4. Are you ISO registered? If Yes, please provide ISO number: _____
5. For how many years do you maintain batch samples of your products? _____
6. Do you conduct regular batch testing (including alcohol % for hand sanitizer)? Yes ☐ No ☐
7. Do you have a formal Product Recall Procedure in place? Yes ☐ No ☐
8. Do you have a formal written Quality Control and/or Quality Assurance program(s) in place? Yes ☐ No ☐
9. Do you maintain all rights of recourse against your suppliers and/or product manufacturers? Yes ☐ No ☐
10. Do you have a Risk Management and Loss Prevention Program in place? Yes ☐ No ☐
11. Please provide your current Pharmaceutical Product Establishment License: _____
12. Please indicate the last date of inspection by Health Canada. _____
13. Do you have procedures for documenting incident reports or complaints? Yes ☐ No ☐

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

14. Do you obtain a certificate of insurance from all suppliers and contractors? Yes O No O
15. Are all contracts reviewed by Legal or your legal representative? Yes O No O
16. 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

Section 8: Prior Insurance

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

Privacy Policy

By signing this form, you are consenting to the collection, use, disclosure, and retention of your personal information for the purposes of underwriting and rating, policy issuance, processing and remitting premium, reporting claims, complying with applicable laws and governing bodies, reporting and monitoring results and fraud and criminal prevention. Please see www.signalunderwriting.com/privacy-statement for our External Privacy Policy.

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

Declarations

I/We, the undersigned, do declare and warrant that all statements and responses provided in this application and the attached addenda are to the best of my/our knowledge are true. Further, I/we warrant that no information has been withheld, suppressed or misstated any material facts that the underwriters may come to rely upon. I/We will notify the underwriters as soon as practicable if anything material is to change. I/We hereby agree and accept that this Declaration shall be the basis of such contract and will form part of the policy. Signing this application does not bind the underwriters or insurers to complete the insurance, nor does it bind the applicant to purchase the quoted coverage.

For British Columbia residents: SIGNAL Underwriting Inc. operates as SIGNAL Underwriting Services in British Columbia.

For Quebec and New Brunswick residents: Signing this Declaration confirms your request that all documentation and correspondence pertaining to the insurance coverage be in the English language.

Name (please print)	Title	Date

Signature

Additonal Information Section

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

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

SIGNAL UNDERWRITING

Life Sciences Application Addenda

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

Addendum: Nutraceuticals and Natural Health Products

1. Please provide the applicant's Natural Health Product site license number: _____
2. Do any of the applicant's products contain any animal derived substances? Yes O No O
3. Do any of the applicant's products make any health claims that have not been published and peer reviewed in a respected medical journal? Yes O No O
4. Have pre-market safety reviews been conducted on any new dietary ingredients? Yes O No O
5. Please identify any product that contains ingredients listed on the FDA's Dietary Supplement Ingredient Advisory List (https://www.fda.gov/food/dietary-supplement-products-ingredients/dietary-supplement-ingredient-advisory-list) * _____
6. Please identify any of the applicant's products that are being marketed as weight management, muscle building or sexual enhancement:* _____
7. Do all of the applicant's products hold a Natural Product Number (NPN) number or DIN? Yes O No O
8. Please include a copy of labels of all the products the applicant manufactures or distributes.
9. Please indicate the applicant's sales by type by approximate percentage (%) of gross revenue:

_____ Amino Acids	_____ Food Products	_____ Minerals
_____ Cosmetics	_____ Herbal Preparations	_____ Vitamins
_____ Enzymes	_____ Homeopathic Medicines	_____ Other, please describe:
_____ Extracts, Oils	_____ Supplements	

Addendum: Contract Manufacturing

1. Do you always use standard contracts prior to providing services (including change orders)? Yes O No O
2. What is the average dollar value of your contracts? _____
3. What is the average duration of your contracts? _____
4. What is the total number of your current contracts? _____
5. 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
6. Please indicate your largest 3 contracts for the current year:

Type of Customer	Contract Value	Services Provided

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

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

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

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