MEDMARC
Treated Fairly
A ProAssurance Company

Medmarc Casualty Insurance Company
ProAssurance Specialty Insurance Company
Life Sciences
Products and Completed Operations Liability Insurance

4795 Meadow Wood Lane
Suite 335 West
Chantilly, VA 20151-2219

Phone: 703-652-1300
Toll free: 1-800-356-6886
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Distributors Insurance Application

This application is for a Claims Made policy.

- **Please answer all questions completely, using attachments if necessary.**
- **Do not leave any space blank. Please indicate "n/a" if a question is not applicable.**
- **If there is insufficient space to answer a question, please attach additional pages.**
- **Please attach current financial information for any privately-held company.**

THIS APPLICATION IS FOR:	☐ New Business	☐ Renewal

Broker Information

1. Company name:			
2. Street:	City:	State:	Zip:
3. Broker contact name:			
4. Broker contact email:		5. Broker contact phone:	
6. License number: *Please provide a copy of the agency license for the state in which the applicant is located.*			

Applicant/Insured Information

7. First named insured: *Please provide the name as it should appear on the policy.*			
8. Desired effective date:			
9. Parent company, if applicable:			
10. Date established:			
11. Street:	City:	State:	Zip:
12. Applicant contact name:		Title:	
13. Website:		Phone number:	

14. First named insured entity structure:

☐ Individual ☐ Partnership ☐ Corporation
☐ Joint Venture ☐ Limited Liability Company ☐ Other (*please describe*)

15. Additional named insured(s), respective percent of ownership, and relationship to you:

Entity name as it should appear on the policy	*% Ownership*	*Relationship*

16. Additional insured(s) and relationship to you:

Entity name as it should appear on the policy	*Relationship*

17. List companies or assets acquired (A) or sold (S) within the last five years.

Entity	*A/S*	*Date Acquired/Sold*	*Description*

18. Provide a description of your operations and products.

19. Do you belong to any industry trade groups? *Check all that apply.*

☐ AdvaMed ☐ MDMA ☐ Other

If other, please list the organization(s). _____

20. Are you accredited by any certifying bodies? *Check all that apply.*

☐ ISO ☐ UL ☐ MedAccred ☐ Other

If other, please list the organization(s). _____

Current Insurance Information

For New Business, please complete the entire section.
For Renewal, please review questions 24 and 25 and complete if applicable.

21. Current insurance company:

22. Current type of insurance: ☐ Occurrence ☐ Claims Made

23. Policy renewal date:

24. Current limit of insurance:
Provide desired limits, if different from current limit.

25. Current self-insured retention or deductible:
Provide desired self-insured retention or deductible, if different from current.

26. Current retroactive date (if claims made):
If more than one, please attach current schedule of retroactive dates.

27. Does your firm currently carry excess liability coverage? ☐ Yes ☐ No

If yes, please provide the coverage information requested below.

Carrier	Limit	*Coverage*	*Claims Made Retro Date*

28. May we provide you with quotes for other lines of coverage?

☐ Manufacturers' Errors and Omissions ☐ Excess Liability

Are you interested in standard lines of coverage (CGL, Auto, Property, Workers' Compensation, Umbrella) available through our partner, Pharmacists Mutual? *If yes, please submit an ACORD application with this application.*

Projected Annual Sales

Manufacturer Represented	*Manufacturer's Country of Domicile*	*Sales – Gross*	
		US	*Foreign*

Projected Annual Sales – Other Sources

	Sales – Gross	
	US	*Foreign*
Leasing		
Service/Maintenance		
Installation		
Other		

If other, please describe.

Product Information

Check box if no changes below in this section. ☐

29. Describe the type of products distributed. *For example, orthopedic implants, dental equipment, radiology equipment, etc.*

30. Does any practicing physician have an ownership stake in your company, or otherwise benefit financially from the sale or use of a product you are selling? ☐ Yes ☐ No	*If yes, please explain.*
31. Do you use indemnification agreements with your suppliers? ☐ Yes ☐ No	*If no, please explain.*
32. Do you require certificates of insurance from your suppliers? ☐ Yes ☐ No	*If no, please explain.*

33. Are any of your products specifically excluded from your current coverage?
☐ Yes ☐ No

If yes, please list the excluded products.

Product Warehousing and Delivery Methods

Check box if no changes below in this section. ☐

34. What methods of product delivery do you employ?

Method	*Percentage*
Delivered by sales representative(s)	
Shipped directly to the customer by you	
Shipped directly to the customer by supplier's manufacturing facility	

35. Where do you take delivery of and store inventory (e.g. at your facility or an off-site facility over which you do not have control)?

☐ Your facility ☐ Off-site rental ☐ Both ☐ Neither

Of what percentage of your product sales do you take possession? _____

36. If you rent storage space outside of your facility/control for products you distribute, do you:

Mandate storage conditions via contract? ☐ Yes ☐ No

Require indemnification by storage vendor via contract? ☐ Yes ☐ No

If no, please explain.

Sales Representatives

Check box if no changes below in this section. ☐

37. How many sales representatives do you use, and what is their status with your company?

Type	*Number*	*Contracts used?*	
Employee(s)		☐ Yes	☐ No
1099 Independent contractor(s)		☐ Yes	☐ No

38. Do any sales representatives enter an operating room? ☐ Yes ☐ No

If yes, in what capacity?

39. Do any sales representatives have patient contact? ☐ Yes ☐ No

If yes, please explain.

40. Do you require evidence of vendors' liability coverage as an additional insured/insured under your manufacturer-supplier's insurance policy?

☐ Yes ☐ No

If yes, please submit copies of certificates of insurance.

41. Please describe the factory training received from manufacturer(s).

42. Please describe Health Care Industry Representatives (HCIR) credentialing.

43. Are your sales representatives trained on the AdvaMed Code of Ethics on Interactions with Health Care Professionals?

☐ Yes ☐ No

Continue to the next page.

Claim/Incident Information

If New Business Application, please answer questions 44, 45, and 46.
If Renewal Application, please answer only question 46.

44. Has any insurance company ever cancelled or refused to renew your insurance?

☐ Yes ☐ No

If yes, please explain.

45. Please attach copies of previous carriers' loss runs for a minimum of the last five years. If loss runs are not available at this time, you may complete the chart below and supply the loss runs prior to binding coverage.

Policy Period	*Carrier*	*# of Claims*	*$ Amount Paid*	*$ Amount in Reserves*

Check here if you have not previously purchased products liability coverage. ☐

46. List any incident(s) and/or circumstance(s) which may result in a claim against you under the coverage requested in this application.

Continue to the next page.

Insurance Fraud Warnings and Important Notices

For your protection, the following warning is required by various state laws: any person who knowingly and with the intent to injure, defraud, or deceive any insurance company or other person, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to criminal and civil penalties, which may include imprisonment, fines, and denial of insurance.

State Specific Fraud Warning Statements

ALABAMA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ARKANSAS / DISTRICT OF COLUMBIA / LOUISIANA / RHODE ISLAND / 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.

CALIFORNIA

For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state 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 policyholders or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim 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.

MAINE / TENNESSEE / VIRGINIA / WASHINGTON

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or 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 willingly 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

Fraud Warning

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.

IMPORTANT NOTICE

In the event you are applying for claims-made coverage, please note the following important information. The information provides you with important guidance in the event your purchase claims-made coverage from us.

1. This is a claims-made policy.

2. This policy is subject to its terms and conditions:

   a. applies only to any claim first made against the insured during the policy period or any applicable Extended Reporting Period; and

   b. does not apply to any claim first made against the insured after the policy period or any applicable Extended Reporting Period or reported after coverage termination.

3. This policy provides no coverage for claims arising out of Occurrences which took place prior to any Retroactive Date shown in the policy.

4. During the first several years of a claims-made relationship, claims made rates are comparatively lower than occurrence rates. The insured can expect substantial annual premium increases, independent of overall rate level increases, until the claims made relationship reaches maturity.

5. All coverage for the policy ceases upon the policy termination date, except for the sixty (60) day automatic Basic Extended Reporting Period, unless an additional Supplemental Extended Reporting Period is purchased.

6. A Supplemental Extended Reporting Period of five (5) years is available for purchase upon the payment of additional premium. Potential coverage gaps may arise upon expiration of the Extended Reporting Period. Within thirty (30) days after policy termination, we will send you written notice describing the Basic Extended Reporting Period, the availability of, and the premium for, and the importance of purchasing additional Extended Reporting Period coverage. You must send us a written notice requesting the Supplemental Extended Reporting Period endorsement within the greater time period of ninety (90) days after termination of coverage or thirty (30) days from our mailing or delivery date of the notice for the Supplemental Extended reporting Period.

7. The rates for the Supplemental Extended Reporting Period will be based upon the rates in effect at the time of coverage termination. Such rates may be subject to substantial increase over the rates currently in effect and such rates may or may not be indicative of future rate changes. Upon your written request, we will provide you with the average statewide percentage changes and the effective date of each rate revision for this particular type of insurance which we have implemented in the state of New York during the five-year period immediately preceding the effective date of the policy.

OHIO

Any person who, with 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 another 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, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

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.

The undersigned authorized officer of the applicant warrants that the statements set forth in this Application are true and complete, and acknowledges and understands that the Medmarc Casualty Insurance Company and its affiliated company, ProAssurance Specialty Insurance Company, are relying on the accuracy and completeness of such information in determining eligibility, qualification, and pricing for the insurance provided. The undersigned also warrants that it has not suppressed or misstated any material facts or made any misleading representations. If the information provided in this Application should change between thedate of the Application and the effective date of the policy, the undersigned warrants that he or she will immediately report such changes to the Insurer. Completing and signing this Application does not bind the undersigned to purchase this insurance, nor does it bind coverage. Coverage will not be bound, nor will a policy be issued, until the applicant signifies acceptance of the company's premium quotation.

(For Montana only, the word "warrants" in the paragraph above is replaced with "represents.")

By signing below, you consent to the receipt of electronic notices and documents (collectively, "Documents"). Documents include any notice or document required as part of an insurance transaction or that is to serve as evidence of coverage. Notwithstanding the previous information, you may request at any time to have a Document sent to you in paper form also. You may also withdraw your consent at any time. Upon information and belief, the only software/hardware requirements for you to access a Document are a valid email address and the ability to open Documents in various formats. You can request a paper copy of a Document withdraw your consent, and/or notify us of a problem opening a Document, by contacting our support team at: LSS@medmarc.com.

Authorized Signature:		**Date:**	
Print Name:			
Title:			
Email:			

If you are electronically submitting this document, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you agree that your use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box 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.

☐ Electronic Signature and Acceptance - Authorized Signature

Please return your signed application using one of the following:
Fax: (703) 652-1389
Email or click Submit: apps@medmarc.com
Mailing: 4795 Meadow Wood Lane, Suite 335 West, Chantilly, VA 20151

Submit