

medical malpractice civil liability insurance policy for healthcare establishments

clinical trials supplementary proposal form



Instructions for completing this Supplementary Proposal Form

1. Failure to disclose all material information that is likely to influence the acceptance of the risk or the terms applied could invalidate the insurance. If you are in any doubt as to whether any information is material, it should be disclosed.
2. Where the space provided is insufficient for your replies, please provide these separately and attach to this Supplementary Proposal Form.
3. Reference to Insured in this Supplementary Proposal Form means:
 - the entity or entities named in question 1; and
 - the past and/or present employees, sole practitioners, partners or directors of the entity or entities named in question 1.

1. Name of all entities to be insured

2. Date that the Proposal Form to which is this is a Supplementary Proposal Form was signed and dated / /

3. Does the Insured require all clinical trial participants to sign an informed consent form? Yes No

If No, please advise what procedures the Insured has in place to obtain the informed consent of participants.

4. When the Insured undertakes clinical trials on behalf of third parties, does the Insured always receive an indemnity from such third parties? Yes No

If Yes, please provide a copy of the indemnity.

5. Please state gross fees/turnover from clinical trials in the last 12 months

6. Please state the following information for each past, current or future trial for which cover is required.
If there are more than four trials photocopy or reprint these pages as necessary.

Trial 1 Title

Phase	Trial Date Start	Trial End Date	Name of Commercial Sponsor / Funding Source	Indemnity Provided	Number of Participants
<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>

Description

Trial 2 Title

Phase	Trial Date Start	Trial End Date	Name of Commercial Sponsor / Funding Source	Indemnity Provided	Number of Participants
<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>

Description

Trial 3

Title

Phase	Trial Date Start	Trial End Date	Name of Commercial Sponsor / Funding Source	Indemnity Provided	Number of Participants
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>

Description

Trial 4

Title

Phase	Trial Date Start	Trial End Date	Name of Commercial Sponsor / Funding Source	Indemnity Provided	Number of Participants
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>

Description

Declaration

I/We the undersigned duly authorised person(s) declare that:

- i. I am/we are authorised by each of the Insured to sign this Supplementary Proposal Form; and
- ii. the above statements are correct, true and complete; and
- iii. no information material to this Supplementary Proposal Form has been withheld; and
- iv. I/we have read the **important facts** which you have put before me/us in the Professional Indemnity Proposal Form and I/we understand the advice given in relation to the **duty of disclosure**; and
- v. I/we have diligently made all necessary and detailed enquiries in order to comply with the **duty of disclosure**; and
- vi. I/we understand that no insurance is in force until such time as the insurer has confirmed acceptance of the proposed insurance; and
- vii. I/we undertake to inform the insurer of any material alteration to these facts occurring before completion of the contract of insurance; and
- viii. I/we acknowledge that the Insurer relies on the information and representations in this Supplementary Proposal Form and otherwise made by me/us in relation to this insurance; and
- ix. except where indicated to the contrary, I/we understand that any statement made in this Supplementary Proposal Form will be treated by the insurer as a statement made by all persons to be insured; and
- x. I/we have read Vero's Privacy Statement which you have put before me/us in the Professional Indemnity Proposal Form, and consent to the use, disclosure and obtaining of personal information about the Insured for the purposes shown in the Privacy Statement; and
- xi. I/we acknowledge that this Supplementary Proposal forms part of the Professional Indemnity Proposal Form signed and dated on the date disclosed in question 2.

Signed

Name of Partner(s) or Director(s)

On behalf of*

*** Insert Name of Firm**

Date

 / /