MEDMARC
Treated Fairly
A ProAssurance Company

Hamilton Resources Corporation
Medical Technology-Life Sciences

14280 Park Meadow Drive, Suite 300
Chantilly, VA 20151-2219

Phone: 703-652-1300 or 800-356-6886
Fax: 703-652-1389

# Request for Quotation for Clinical Trials Outside of the United States

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.

| **Broker Information** | | |
|---|---|---|
| 1. Company Name: | | |
| 2. Address: | | |
| 3. Primary Contact Name: | 4. Email: | Phone: |
| | | |
| 5. License #:<br>Please provide copy of agency license (must be for state in which applicant is located). | | |

| **Applicant Information** | |
|---|---|
| 6. Named Insured: | |
| 7. Desired Effective Date: | |
| 8. Parent Company (If Any): | |
| 9. Address: | |
| 10. Website: | |
| 11. Phone Number: | |
| 12. Named Insured is: ☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ LLC Other (Describe) | |
| 13. Is the named insured the trial sponsor? | ☐ Yes ☐ No |
| If no, please explain. | |

| **Applicant Contact Information** | | | |
|---|---|---|---|
| | Name: | Title: | Email: |
| 14. Primary: | | | |
| 15. Billing: | | | |

| **Please complete 1-18 below for each country the study will take place** | | |
|---|---|---|
| 1. Country: | | |
| 2a. Estimated Start Date:<br>2b. Estimated End Date:<br>(Includes Patient Monitoring) | 3a. First Patient In Date:<br>3b. Last Patient Out Date: | |
| 4. Local Contact Name: | 5. Email: | 6. Phone: |
| | | |
| **What facility will be doing the testing:** | | |
| 7. Name: | 8. Address: | |
| | | |
| 9. Chief Investigator: | 10. Email: | 11. Phone: |
| | | |
| 12. For European Sponsor, please provide VAT Number: | | |
| 13. Protocol Number: | | |
| 14. Study Title: | | |
| 15. Product being tested, drug or device? | | |
| 16. Product or procedureis being tested? | | |
| 17. What phase if this is a Drug test? | | |
| 18. Number of participants being tested? | | |

**Please attach the Draft Protocol and the Draft Participant Information Sheet for quote. Final Protocol and Participant Informations Sheet will/may be required before policy or certificate can be issued.**

**Every country has additional requirements which we will ask for after we review your submission.**

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 and premium payment is made.

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

**Please return your signed application using one of the following:**
Fax: (703) 652-1389
Email: Apps@medmarc.com
Mailing: 14280 Park Meadow, Suite 300, Chantilly, VA 20151

Submit