**Insurance Application for Clinical Trials**

The information provided in this application form will be used by underwriters to provide an insurance quotation. Additional information may be required based on information submitted under this application. Details must be provided in English. Based on local country requirements, protocol name may be required in that local language. Depending on the complexity of the trial and the number of jurisdictions involved, a 14 working day turnaround time may be required to provide a quotation.

An insurance quotation is required by what date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Clinical Trial Details** |
| Named Insured: | The Governors of the University of Alberta |
| Name of Trial: |  |
| Confirm Scope of Trial (summary) |  |
| Sponsor(s): |  |
| Parties contracting to sub-sites: |  |
| UA Principal Investigator Full Name (First/Last): |  |
| UA Principal Investigator Title: |  |
| Department/Faculty:  |  |
| Department Speed Code (insurance payment): |  |
| Name of Protocol Author & Organization: |  |
| The study is Phase I, II, III, IV or other |  |
| Lead Site: |  |
| Total Number of Countries: |  | # of Participants  |  |
| Recruitment Period (# of months): |  |
| Duration of Study (# of years): |  |
| Ethics Approval Date: (Month/Day/year): |  |
| Estimated Revenue: |  |
| Drug or device: |  |
| Who is providing device/drug to sub-sites: |  |
| Describe new UA owned/leased equipment & replace value to be insured as part of this trial: |  |

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| **Sub-Sites****Countries** | **Number****of Participants** | **Investigator Full Name & Site Address** | **Expected Start Date of Enrollment of First Subject (MMDDYR)** |
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A copy of the study protocol, informed consents and draft agreements must be included as part of this application form.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Written Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_