

**PREMIERE PRODUCTION PACKAGE  
APPLICATION**

Supple-Merrill & Driscoll, Inc.  
CA Lic. 0517777

Phone: (626) 795-9921  
Fax: (626) 844-6403  
[ProductionInsurance.com](http://ProductionInsurance.com)

**PLEASE COMPLETE THIS APPLICATION, AND SUBMIT WITH SCRIPT AND BUDGET.**

Agent/Broker: Supple-Merrill & Driscoll, Inc. Date of Application: \_\_\_\_\_

Address: 550 El Dorado Street, Pasadena, California 91101

Contact: David L. Merrill Telephone Number: (626) 795-9921

E-Mail [david@productioninsurance.com](mailto:david@productioninsurance.com) Fax Number: (626) 844-6403

**APPLICANT INFORMATION**

1. Name of Applicant: \_\_\_\_\_

2. Address: \_\_\_\_\_

3. Title of the Covered Production: \_\_\_\_\_

4. Proposed Policy Effective Dates From: \_\_\_\_\_ To: \_\_\_\_\_

5. Production Schedule

a) Period of Pre Production: From: \_\_\_\_\_ To: \_\_\_\_\_

b) Period of Principal Photography: From: \_\_\_\_\_ To: \_\_\_\_\_

c) Period of Post Production: From: \_\_\_\_\_ To: \_\_\_\_\_

6. Requested Coverages

a) Section 1 Cast Protection	Limit	Deductible
<input type="checkbox"/> 1A Extended Pre-Production Cast Protection	\$	
<input type="checkbox"/> 1B Principal Photography Cast Protection	\$	
<input type="checkbox"/> 1C Post Production Cast Protection	\$	
b) Section 2 Negative Film and Faulty Stock		
<input type="checkbox"/> 2A Negative Film & Videotape Protection	\$	
<input type="checkbox"/> 2B Faulty Stock, Camera & Processing Protection	\$	
c) Section 3 Supplemental Coverages		
<input type="checkbox"/> 3A Props, Sets & Wardrobe Protection	\$	
<input type="checkbox"/> 3B Miscellaneous Equipment Protection	\$	
<input type="checkbox"/> 3C Property Damage Liability Protection	\$	
<input type="checkbox"/> 3D Extra Expense Protection	\$	
d) Section 4 Optional Coverages		
<input type="checkbox"/> 4A Business Personal Property Protection	\$	
<input type="checkbox"/> 4B Nonowned and Hired Auto Physical Damage Protection	\$	
<input type="checkbox"/> 4C Money, Securities and Collateral Protection	\$	
<input type="checkbox"/> 4D Animal Mortality Protection	\$	

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7. The applicant is:  An Individual  A Partnership  A Corporation  LLC \_\_\_\_\_

If the Applicant is a Corporation, please provide the following names.

President \_\_\_\_\_ Vice President \_\_\_\_\_

Secretary \_\_\_\_\_ Treasurer \_\_\_\_\_

8. Director \_\_\_\_\_ Producer \_\_\_\_\_

Production Mgr \_\_\_\_\_ Director of Photo \_\_\_\_\_

9. Producer's Prior Productions: \_\_\_\_\_

Title	Insurance Carrier

10. Has the Producer had any Production Insurance declined or canceled in the past five years?  Yes  No

If Yes, explain \_\_\_\_\_

11. Losses over \$50,000 in the past five (5) years: \_\_\_\_\_

12. Source of Financing: \_\_\_\_\_

13. Release or Distribution Organization: \_\_\_\_\_

14. Completion Bond Company (if none, please state so) \_\_\_\_\_

15. Premium Audit Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

16. The Production is:

Feature Film for Theatrical Release

Television Production

Movie for Television  Pilot  Special  Series  Mini Series  Other: \_\_\_\_\_

17. Running Time (e.g. 30 min, 60 min, 90 min): \_\_\_\_\_

Number of Series Episodes: \_\_\_\_\_

18. Type of Story (e.g. Drama, Comedy, Musical, Western): \_\_\_\_\_

19. Storyline: \_\_\_\_\_

20. Shooting Locations used during Principal Photography: \_\_\_\_\_

Description of Location (Including City, State, Country)	Period of time at Each location

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21. Medical Facility:

Describe arrangements made for First Aid and access to medical facilities and identify the person in charge and responsible for making arrangements:

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22. The Production involves (check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Use of Animals             | <input type="checkbox"/> Underwater Filming |
| <input type="checkbox"/> Motorcycles                | <input type="checkbox"/> Special Vehicles   |
| <input type="checkbox"/> Airborne Crafts            | <input type="checkbox"/> Waterborne Crafts  |
| <input type="checkbox"/> Railroad Cars or Equipment |   |

*If any of the above are checked, describe in detail and attach to this application*

- Pyrotechnics (Explosions, fire) Complete Supplemental Application  
 Stunts or Hazardous Activities Complete Supplemental Application

23. Estimated costs of each Production or Episode

- |   |          |
|---|----------|
| o Total Budget (including budgeted deferrals):                | \$ _____ |
| o Story/Scenario; Screenplay & Re-writing & associated costs: | \$ _____ |
| o Post Production Costs:                                      | \$ _____ |
| o Gross Insurable Production Costs (a minus b & c)            | \$ _____ |
| o Music, Sound Rights, Records and Royalties                  | \$ _____ |
| o Net Insurable Production Costs (d minus e)                  | \$ _____ |
| o Total Below The Line Costs                                  | \$ _____ |

24. Indicate if any of the following **Optional items** are to be insured

- |   |          |
|---|----------|
| <input type="checkbox"/> Story/Underlying Rights, Screenplay, Re-Writes | \$ _____ |
| <input type="checkbox"/> Sound/Music Rights, Recording Costs            | \$ _____ |
| <input type="checkbox"/> Indirect Overhead                              | \$ _____ |
| <input type="checkbox"/> Royalties                                      | \$ _____ |
| <input type="checkbox"/> Other (describe): _____                        | \$ _____ |

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**Note: Attach copy of Contract or Deal Memo for each person to be insured for Cast Coverage.**

25. CAST COVERAGE DESIRED

EXTENDED PRE PRODUCTION CAST PROTECTION

Described Artist	Role/Position	Age	Coverage Period	Limit of Coverage
Total Limit:				

a) Are employment contracts "Pay or Play"?  Yes  No

b) Do employment contracts contain "Tie-In" Arrangements?  Yes  No

If yes, explain: \_\_\_\_\_

c) Will any persons insured by the policy be involved in any hazardous activities during the term of the coverage?  Yes  No

If yes, explain: \_\_\_\_\_

PRINCIPAL PHOTOGRAPHY CAST PROTECTION

Described Artist	Age	Role/Position	Stop Date
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Please give particulars on any Stop Date question answered "Yes"

POST PRODUCTION CAST PROTECTION

Described Artist	Age	Function or Responsibilities During Post Production	Coverage Period	Stop Date
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Please give particulars on any Stop Date question answered "Yes":

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**NEGATIVE FILM/ VIDEOTAPE**

Name and Location of:

a) Processing Laboratory: \_\_\_\_\_

b) Storage Vaults: \_\_\_\_\_

c) Editing Facility: \_\_\_\_\_

d) Post Production Facility: \_\_\_\_\_

e) Will original negative film material leave the above premises prior to the completion of a protection Print?  Yes  No

If yes, explain: \_\_\_\_\_

f) Will the processing frequency during principal photography be on a daily basis?  Yes  No

If No, explain: \_\_\_\_\_

g) How will original negative material be transported from the filming location(s) to the processing laboratory?  
\_\_\_\_\_

h) Film Type (e.g. 35mm, 70mm) : \_\_\_\_\_

i) Is Videotape used in lieu of negative film?  Yes  No

j) Are Animation or Computer Generated Graphics used?  Yes  No

If Yes - Created or Generated by whom: \_\_\_\_\_ Locations: \_\_\_\_\_

k) Estimated completion date of protection print: \_\_\_\_\_

l) Coverage to be effective: \_\_\_\_\_ Limit of Coverage: \$ \_\_\_\_\_

**FAULTY STOCK, CAMERA AND PROCESSING**

a) Use of secondary market raw stock:  Yes  No

b) Will new experimental technology; cameras and/or equipment be used in the filming of the project?  Yes  No

If "Yes" please explain and provide names and qualifications of persons experienced in the technology:  
\_\_\_\_\_  
\_\_\_\_\_

c) Name and position of person(s) responsible for conducting testing of cameras and raw stock:

(Name) \_\_\_\_\_ (Position) \_\_\_\_\_

Limit of Coverage \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_

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PROPS, SETS AND WARDROBE

a) Value of Owned: \_\_\_\_\_ Non-owned: \_\_\_\_\_

b) List items with an insurable value in excess of \$250,000 each: \_\_\_\_\_

c) List any individual items of antiques, objects of art, rugs, furs, jewelry, precious or semi precious stones/ metals/ alloys in excess of \$10,000: \_\_\_\_\_

d) Name and position of person(s) responsible for security and protection of Props, Sets, and Wardrobe

(Name) \_\_\_\_\_ (Position) \_\_\_\_\_

e) Coverage required: From \_\_\_\_\_ Until \_\_\_\_\_

Limit of Coverage \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_

MISCELLANEOUS EQUIPMENT

a) Value of Owned \_\_\_\_\_ Non-owned: \_\_\_\_\_

b) List any individual item(s) over \$250,000: \_\_\_\_\_

c) Brief description of protection of property (fire fighting equipment, watchmen, etc.): \_\_\_\_\_

d) Where will the equipment be kept during use? \_\_\_\_\_

e) Location to which the equipment will be returned when not in use: \_\_\_\_\_

f) Name and position of person(s) responsible for security and protection of equipment:

(Name) \_\_\_\_\_ (Position) \_\_\_\_\_

g) Coverage required: From \_\_\_\_\_ Until \_\_\_\_\_

h) Limit of Coverage \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_

THIRD PARTY PROPERTY DAMAGE

a) Brief description of property other than miscellaneous equipment, props, set, etc.) or facilities to be used in connection with the production for which the Applicant may be responsible \_\_\_\_\_

b) Coverage required: From \_\_\_\_\_ Until \_\_\_\_\_

c) Limit of Coverage \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_

EXTRA EXPENSE (as a result of loss of or damage to property or facilities used in connection with the production)

a) Estimated time needed to reconstruct destroyed key facilities, sets or scenery: \_\_\_\_\_

b) Estimated time needed to replace lost or destroyed equipment: \_\_\_\_\_

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c) What alternative location or studio facilities would be immediately available?

d) Coverage required: From \_\_\_\_\_ Until \_\_\_\_\_

e) Limit of Coverage \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_

BUSINESS PERSONAL PROPERTY

a) Full Address of Premises/Location(s): \_\_\_\_\_

b) Value Owned: \$ \_\_\_\_\_ Rented \$ \_\_\_\_\_

c) Coverage required: From \_\_\_\_\_ Until \_\_\_\_\_

d) Limit of Coverage \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_

MONEY AND SECURITIES

a) Maximum amount of cash on hand at any one location: \$ \_\_\_\_\_

b) Total cash on hand at all times at all locations: \$ \_\_\_\_\_

c) Name and position of person(s) responsible for the handling and safekeeping of money and securities:

(Name) \_\_\_\_\_ (Position) \_\_\_\_\_

d) Coverage required: From \_\_\_\_\_ Until \_\_\_\_\_

e) Limit of Coverage \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_

NON OWNED AND HIRED AUTO PHYSICAL DAMAGE

Cost of Hire: Mobile Studio Units and Film Trucks \$ \_\_\_\_\_

Other than above \$ \_\_\_\_\_

Percentage of Private Passenger Vehicle  Less than 50% of all vehicles

Less than 25% of all vehicles

OTHER COVERAGES (Describe)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**MEDICAL CAST APPLICATION**

Please complete application and send all attachments:

Agent/Broker: Supple-Merrill & Driscoll, Inc. Date of Application \_\_\_\_\_  
Address: 550 El Dorado Street, Pasadena, California 91101  
Contact: David L. Merrill Telephone Number: (626) 795-9921  
E-Mail [david@productioninsurance.com](mailto:david@productioninsurance.com) Fax Number: (626) 844-6403

NAME OF ARTIST \_\_\_\_\_  
ARTIST'S ROLE  Actor  Director  Other: Describe: \_\_\_\_\_  
NAME OF PRODUCTION \_\_\_\_\_  
PRODUCTION COMPANY \_\_\_\_\_

**ARTIST'S STATEMENT OF DECLARED HEALTH  
(Must be completed by artist shown above)**

1. Name, Address and Telephone Number of your personal physician (If none, so state)
  - a) Name of your personal physician \_\_\_\_\_
  - b) Physician Address: \_\_\_\_\_
  - c) Physician Telephone Number \_\_\_\_\_
2. When were you last examined? \_\_\_\_\_ Why? \_\_\_\_\_  
Results: \_\_\_\_\_
3. To the best of your knowledge are you in good health and free from physical impairment or disease  Yes  No  
If No, please explain: \_\_\_\_\_

**If any of the following questions are answered "YES" please explain in the space provided on the "Comments" section:**

4. Have you to the best of you knowledge and belief, ever had or been informed you have/had:
  - a) Allergies, anemia or disorder of the blood?  Yes  No
  - b) Any disease, disorder or injury of the bones, joints, muscles, back, spine, or neck?  Yes  No
  - c) Any disorder of the skin, lymph glands, immune system, cyst, tumor or cancer?  Yes  No
  - d) Any infections or diseases of eyes, ears, nose or throat in the past 5 years?  Yes  No
  - e) Cold sores on lips or face in the past 5 years?  Yes  No
  - f) Convulsions, paralysis or stroke, fainting attack, severe headaches or disease of the brain or nervous system?  Yes  No
  - g) Diabetes, gout or any disease or abnormality of the thyroid or other glands?  Yes  No
  - h) Duodenal or gastric ulcer, colitis, or any other disease or abnormality of the stomach, intestines, rectum, liver, pancreas, gallbladder or hernia?  Yes  No
  - i) High blood pressure, heart attack, pain in chest, or any other disorder of the heart or blood vessels?  Yes  No
  - j) Sugar, albumin, blood or pus in urine, kidney stones, or any other disorder of the bladder, kidney or genito-urinary system?  Yes  No
  - k) Tuberculosis, asthma, emphysema, persistent cough or any disease or abnormality of the lungs or respiratory system?  Yes  No





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**AFFIDAVIT**

**I declare** that I am the person named above, that the statements made by me on the pages of this Statement of Declared Artist are true, correct and complete, and that I have not withheld information known to me which might alter or otherwise conflict with the statements made by me on this Statement.

**I declare** that, during the period of this production, I will continue to take any medications or follow any course of treatment currently prescribed to me by my personal physician(s) as indicated on this Statement.

**I understand** that coverage for insurance may be granted based upon the representations and facts stated by me on this Statement as true. In the event coverage of insurance is granted and a claim is paid pursuant to the policy, and it is determined later that the facts set forth above are not true, the insurer may seek recoupment from me or my estate for such payment and hold me or my estate personally responsible for same. I further agree to cooperate with any claim investigation and to be examined by insurer's doctors in the event a claim is made.

**AUTHORIZATION TO RELEASE INFORMATION**

**I hereby direct**, authorize and request any physician, medical practitioner, hospital, laboratory, health care provider, or insurance company to permit the insurer or its representative, production company, insurance broker, or their agents to review and copy all medical reports, x-rays, charts, records and other data in the Medical Records Holders possession or control that pertain in any manner to my medical history, physical or mental condition, care and/or treatment. The Medical Records Holder is also authorized to discuss such information or provide a written report as necessary. This information is to be used for the purpose of processing, verifying, investigating and/or evaluating an application for insurance, a claim for insurance benefits or responsibility for payment or legal liability in relation to the above named production. This authorization shall be considered valid for twenty four (24) months from the date on which it is signed. A copy of this authorization shall be considered as valid as the original, and I am entitled to receive a copy of this authorization if I request.

**Signature of Declared  
Artist/Guardian**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Print Name(s)**

\_\_\_\_\_

**Date of Birth**

\_\_\_\_\_

**Age**

\_\_\_\_\_

**Sex**

\_\_\_\_\_

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**PHYSICAL EXAMINATION  
(TO BE COMPLETED BY THE EXAMINING PHYSICIAN)**

Date Of Examination \_\_\_\_\_  
Location Of Examination \_\_\_\_\_  
Examining Physician \_\_\_\_\_  
Physician's Address \_\_\_\_\_  
Physician's Phone \_\_\_\_\_  
General Appearance of Examined Artist \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Temp \_\_\_\_\_  
Pulse \_\_\_\_\_ BP \_\_\_\_\_ EENT \_\_\_\_\_  
Heart \_\_\_\_\_ Lungs \_\_\_\_\_ Abdomen \_\_\_\_\_

**PHYSICIAN'S COMMENTS:** (Please complete any further examination you deem necessary as a result of your findings or Examinee's history and comment on any condition revealed by artist. Please include notes on examination and any abnormal findings and recommendations. If additional space is needed, please use additional pages.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- In my professional opinion, the artist **is** in sound health and free from disease and **is** in a fit condition, subject to any qualifications mentioned above, to fulfill his/her production/performance/engagement.
- In my professional opinion, the artist **is not** in sound health and free from disease and **is not** in a fit condition, subject to any qualifications mentioned above, to fulfill his/her production/performance/engagement.

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_  
Qualifications/License of Physician \_\_\_\_\_  
\_\_\_\_\_

**FOR INSURANCE COMPANY PURPOSES ONLY**

Date Received: \_\_\_\_\_ Underwriter \_\_\_\_\_  
Coverage Grant:  Accident Only  Unrestricted Coverage  Coverage with restrictions  
Restrictions \_\_\_\_\_

Date Stamp: