

# Vendor Information Form (Life)

(To be completed by Insurer or MGA)

**Please note:** It is important to provide complete information as requested on this form, such as project scope, licensed products for which the request is being made, and timeline of the project. If the information is incomplete, it may result in delays in considering your request. If you have any questions about the form, please contact your Account Executive or Account Manager.

Date: \_\_\_\_\_

Your Company Name (Insurer/MGA): \_\_\_\_\_

Verisk Account Executive/Manager: \_\_\_\_\_

IRD Number: \_\_\_\_\_ Address: \_\_\_\_\_

Your Name (Contact completing form): \_\_\_\_\_

Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Additional Contact Information: \_\_\_\_\_

**Please complete a separate form for each vendor. Note: Vendor may be subject to an administrative fee.**

Vendor Name: \_\_\_\_\_

Address: \_\_\_\_\_

Vendor Contact Name: \_\_\_\_\_

Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Additional Contact Information: \_\_\_\_\_

**1. This vendor will be developing:**

- Policy administration system
- Underwriting System
- Agency Management Software
- e-app
- Claims Administration System
- ICustomer Relationship Management System
- Other \_\_\_\_\_

**2. Please indicate which of the following product(s) this vendor will have access on behalf of your company (Insurer or MGA) for the project described in section 4:**

<b>Verisk Life Insurance Solutions</b>
ISO:
<input type="checkbox"/> Tobacco Usage Propensity Model
<input type="checkbox"/> Avocation Model
<input type="checkbox"/> EHR Triage Engine
<input type="checkbox"/> Other [Describe]:
iiX:
<input type="checkbox"/> MVR Reports (full detail)
<input type="checkbox"/> MVR Reports – Index of Activity (IoA)

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<input type="checkbox"/> MVR Indicator (If only indicator is checked, select who will be providing the full detail MVR) <input type="checkbox"/> ISO <input type="checkbox"/> State <input type="checkbox"/> Other 3 <sup>rd</sup> party Vendor _____ Other Verisk Business/Product:
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**3. Please identify the name of the system or service that the vendor is providing to your company in the project described in section 4:**

**4. Describe in detail how the vendor will be using the Verisk material for this project:**

**5. The product being delivered by the vendor to the Insurer/MGA is:**

As is (not customized)                       Customized  
 Other: \_\_\_\_\_

**6. Where will the work be done by the vendor? *(Please note: There are limitations/restrictions regarding 3<sup>rd</sup> parties accessing data off-shore. If you are working with a 3<sup>rd</sup> party vendor who will be using off-shore resources or locations, please contact your Account Executive or Account Manager to discuss):***

Insurer site                                       Vendor site  
  
 Other: \_\_\_\_\_

In which state(s), territory(ies), or country(ies) would the Insurer/MGA or its authorized users, if any, be using the vendor products? \_\_\_\_\_

**7. Does the 3rd party vendor have any non-US, offshore resources requiring access to the Verisk products/data specified in item #2? (Note: For certain products/data this would not be permitted):**

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**8. Where will the materials/data/connection be hosted?**

- Insurer site  Vendor site
- Third Party Cloud Provider

In which state(s), territory(ies), or country(ies) will the products be hosted?

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**9. If you are using or will be using the vendor's policy administration system, who will be supporting your instance of the vendor's system/application in production? (Ex. If 3<sup>rd</sup> party off-shore vendor and has been approved for UAT access only, who will help support you in production?)**

- Insurer  Vendor
- Other: \_\_\_\_\_

**10. If applicable, who will be doing production releases of the vendor's product after the project/implementation of the Verisk product is complete?**

- Insurer  Vendor
- Other: \_\_\_\_\_

**11. How long will you be working on this project with the vendor? (Please note: The standard term for consultant licenses is 6-12 months).**

Start date \_\_\_\_\_  
End date \_\_\_\_\_

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CERTIFICATION OF CUSTOMER

I am an authorized representative from the above Insurer or MGA to certify that this is a complete and accurate statement of the work we are requesting from the above Vendor.

We require the Vendor to use product(s) indicated in section 2 only as permitted by the terms and conditions of our applicable license for the product(s). We understand that we are responsible to Insurance Services Office, Inc., its subsidiaries and affiliates (ISO) for any Vendor use or misuse of the products that are made available to the Vendor on our behalf.

You also must affirmatively acknowledge, warrant, and represent the following by checking one of the below boxes:

I am not a Covered Entity or Business Associate as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I am a Covered Entity or Business Associate under HIPAA and have complied with any and all applicable requirements necessary for the provision to ISO of any data subject to HIPAA, which includes obtaining any required individual authorizations concerning such data. ISO may use such data for the products and services as contemplated by license agreement.

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

Phone: \_\_\_\_\_

Please e-mail the completed form to your ISO/Verisk account executive/account manager as well as [strategicalliances@verisk.com](mailto:strategicalliances@verisk.com).