



**OneBeacon Insurance Company**  
 c/o First Media  
 4350 Shawnee Mission Pkwy #350 – Fairway, KS 66205  
 800-753-7545/913-384-4800 Fax: 913-384-4822 www.firstmediainc.com

## Media Advantage Policy<sup>®</sup> Cable Television Operator Renewal Application

All Questions Must Be Answered Completely.  
 Attach Additional Sheet If Necessary.

**NOTE:** Unless the policy form provides coverage for Defense Costs in Addition to the Limits of Liability, the Limits of Liability shall be reduced by defense costs. Renewal of the expiring Media Advantage Policy<sup>®</sup>, Endorsements and Declarations is not automatic. Please return the completed Renewal Application promptly so that we can advise of renewal terms or of our inability to renew coverage.

**1. Named Insured Information**

Named Insured \_\_\_\_\_

Policy Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

**2.** Advise of any changes to the Named Insured's address, phone number, fax or e-mail address or other contact information: \_\_\_\_\_

**3. Cable Systems** — Please attach separate sheet, if necessary.

| System and Location | Years in Operation | Number of Access Channels | Number of Subscribers | Annual Revenues | Geographic Regions Served |
|---------------------|--------------------|---------------------------|-----------------------|-----------------|---------------------------|
|                     |                    |                           |                       |                 |                           |
|                     |                    |                           |                       |                 |                           |
|                     |                    |                           |                       |                 |                           |

**4. Originated Programming:**

Please identify new programming produced by the Named Insured and identify the cable system through which it is broadcast: \_\_\_\_\_

Total hours of original programming per week \_\_\_\_\_

Do cable systems share original programming:  Yes  No

If "yes" to above, indicate percentage of duplication \_\_\_\_\_ %

Is original programming syndicated?  Yes  No

Does the **Applicant** produce local news coverage?  Yes  No

If "yes" to above, indicate percentage \_\_\_\_\_ %

**5. Access Channels**

Hours of daily broadcasts by access channels \_\_\_\_\_

Please describe access procedure \_\_\_\_\_

**6. Leased Channels**

Please identify percentage of leased channels \_\_\_\_\_ %

Are users required to execute a written hold-harmless agreement and indemnify the cable operator?  Yes  No

**7. Claim Information**

Has the Insured been involved in a media liability lawsuit or claim, which has not yet been reported to the Company?  Yes  No

If "yes," please attach detailed information, including suit papers or demand letters.

If the Insured has Subpoena Defense Coverage or is seeking to add this coverage, please attach detailed information regarding the circumstances of any subpoenas, which have not been reported.

**8. Other Information**

Advise of any other important changes from the original Application that might affect this coverage:

\_\_\_\_\_

**Fraud Warning**

**Any person who knowingly and with intent to defraud any insurance company or another person files an application of insurance containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and (NY: substantial) civil penalties. In Maine and Virginia, insurance benefits may also be denied.**

**PLEASE NOTE: THIS FRAUD WARNING DOES NOT APPLY TO INSURANCE GOVERNED BY THE LAWS OF CANADA.**

The statements made in this Renewal Application for insurance and in any attachments are true and correct to the best of my knowledge

Insured \_\_\_\_\_ Title \_\_\_\_\_  
(Director, Partner or Principal)

Signature \_\_\_\_\_ Date \_\_\_\_\_

**If this is your first submission to First Media, please complete the following :**

Name \_\_\_\_\_ License No. \_\_\_\_\_ Exp. Date \_\_\_\_\_

Agency \_\_\_\_\_ Agency Tax Payer I.D. \_\_\_\_\_

Address \_\_\_\_\_ City and State/Province \_\_\_\_\_

Zip/Postal Code \_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_

E-Mail \_\_\_\_\_