

- Western World Insurance Company
- Tudor Insurance Company
- Stratford Insurance Company

Application  
For  
**Emergency Care Services  
Professional Liability**

1. Name of Applicant \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Applicant's Web Site Address \_\_\_\_\_

2. Type of Organization
- |  |                                     |                                      |
|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Volunteer   | <input type="checkbox"/> Individual | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Corporation   | <input type="checkbox"/> For-Profit | <input type="checkbox"/> Non-Profit  |
| <input type="checkbox"/> Municipality (Fully describe interest, control, financial support.) _____ |                                     |                                      |
| <input type="checkbox"/> Other (Please explain.) _____   |                                     |                                      |

Is Applicant owned or operated by a hospital?  Yes  No

3. Date Established \_\_\_\_\_

4. Population of Area Served \_\_\_\_\_ Radius of Operation \_\_\_\_\_ Miles

5. Sales (If applicable.) \$ \_\_\_\_\_ Number of Volunteer Members \_\_\_\_\_  
 Number of Paid Members \_\_\_\_\_

6. Has the applicant had previous insurance for this enterprise?  Yes  No  
 (If yes, please complete the following.)

Insurance Company	Policy Period	Limits of Liability	Premium	Type of Coverage	Occurrence or Claims Made

7. During the past **three (3) years**, have any claims been presented to your current or prior insurance carrier(s)? *If yes, please provide description of claim(s), date of loss, amount(s) paid and reserved on Attachment to A13.*  Yes  No
8. Is the applicant, or any other person for whom insurance is being requested, aware of any circumstances which may result in a claim? *If yes, please provide full details on Attachment to A13.*  Yes  No
9. Has the applicant, or any other person for whom coverage is being requested, had any application for liability insurance denied, policy cancelled or non-renewed in the past **three (3) years**? *If yes, please provide full details on Attachment to A13.*  Yes  No

10. Type of Service
- |   |  |
|---|--|
| <input type="checkbox"/> Ambulance                      | <input type="checkbox"/> First Responder                   |
| <input type="checkbox"/> Paramedic                      | <input type="checkbox"/> Alarm Monitoring                  |
| <input type="checkbox"/> Rescue Squad with Ambulance    | <input type="checkbox"/> Rescue Squad without Ambulance    |
| <input type="checkbox"/> Fire Department with Ambulance | <input type="checkbox"/> Fire Department without Ambulance |
| <input type="checkbox"/> Individual EMT                 | <input type="checkbox"/> Individual Paramedic              |
| <input type="checkbox"/> Dispatch Service for Others    | <input type="checkbox"/> Other (Please specify.) _____     |

11. Number of Operational Ambulances \_\_\_\_\_ EMT's \_\_\_\_\_  
 Stand-By Ambulances \_\_\_\_\_ Paramedics \_\_\_\_\_  
 Chair Cars/Vans/Mini Vans \_\_\_\_\_ First Responders \_\_\_\_\_

12. Number of Annual Calls Emergency \_\_\_\_\_  
 Non-Emergency (Ambulance) \_\_\_\_\_  
 Non-Emergency (Transport) \_\_\_\_\_

Do all non-emergency transport drivers have CPR or Red Cross lifesaving training?  Yes  No

13. Number of Crew Per Ambulance \_\_\_\_\_ Number of Hours of Annual Training for Each \_\_\_\_\_  
 EMTS \_\_\_\_\_  
 Paramedics \_\_\_\_\_  
 Nurses \_\_\_\_\_  
 Other \_\_\_\_\_

(Please describe "Other" crew.) \_\_\_\_\_

14. Current General Liability Insurer \_\_\_\_\_  
 Current Auto Insurer \_\_\_\_\_ Limits \_\_\_\_\_

Does auto insurer exclude liability for loading and unloading?  Yes  No

15. Fully describe any hospital/nursing home affiliation. \_\_\_\_\_  
 \_\_\_\_\_

16. Please provide details of any mutual aid agreements (attach a copy of agreement to this application).

Additional Insureds	Describe Interests of Additional Insureds

17. Do you perform background checks on all employees that include checking prior employer, police, references?  Yes  No

18. Has the Applicant had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct?  Yes  No

**19. Limits of Insurance Requested**

General Aggregate Limit (Other than Products-Completed Operations) \$ \_\_\_\_\_  
 Products-Completed Operations Aggregate Limit \$ \_\_\_\_\_  
 Personal and Advertising Injury Limit \$ \_\_\_\_\_  
 Each Occurrence Limit \$ \_\_\_\_\_  
 Damage to Premises Rented by You (Up to \$50,000 Limit Available) \$ \_\_\_\_\_ Any One (1) Premises  
 Medical Expenses Limit (Up to \$5,000 Limit Available) \$ \_\_\_\_\_ Any One (1) Person  
 Each Professional Incident Limit (If Applicable) \$ \_\_\_\_\_

20. Effective Dates Desired – From: \_\_\_\_\_ To: \_\_\_\_\_

Applicant's Signature \_\_\_\_\_  
 Title \_\_\_\_\_  
 Date \_\_\_\_\_  
 Producing Agent \_\_\_\_\_

