

- 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:  Volunteer  Individual  Partnership  
 Corporation  For-Profit  Non-Profit  
 Municipality (Fully describe interest, control, financial support.) \_\_\_\_\_  
 Other (Please explain.) \_\_\_\_\_

Is Applicant owned or operated by a hospital?  Yes  No

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

4. What state/s are you licensed or certified in? Provide details of what your license/certification allows you to do.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Population of Area Served \_\_\_\_\_ Radius of Operation: \_\_\_\_\_ Miles

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

7. 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

8. 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

9. 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

10. 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

11. Type of Service:
- Ambulance
  - First Responder
  - Paramedic
  - Alarm Monitoring
  - Rescue Squad with Ambulance
  - Rescue Squad without Ambulance
  - Fire Department with Ambulance
  - Fire Department without Ambulance
  - Individual EMT
  - Individual Paramedic
  - Dispatch Service for Others
  - Other (Please specify.)

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

13. 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

14. Number of Crew Per Ambulance \_\_\_\_\_ Number of Hours of Annual Training for Each \_\_\_\_\_  
 EMTS \_\_\_\_\_  
 Paramedics \_\_\_\_\_  
 Nurses \_\_\_\_\_  
 Other \_\_\_\_\_  
 (Please describe "Other" crew.) \_\_\_\_\_

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

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

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

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

Additional Insureds	Describe Interests of Additional Insureds

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

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

20. **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) \$ \_\_\_\_\_

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

Applicant's Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

Producing Agent \_\_\_\_\_

