Member Companies of Western World Insurance Group

☐ 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. 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
    ☐ 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.) ____________

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 ____________________

Application For **Emergency Care Services** *Attachment to A13*

Name of Applicant ______________________________

#	Description or Full Details