Member Companies of Western World Insurance Group

☐ Western World Insurance Company
☐ Tudor Insurance Company
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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