

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

**Application
For
Emergency and Non-Emergency Medical Transport
Professional Liability and/or CGL**

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 _____ Limits _____
 Current Auto Insurer _____
 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 _____