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) ______

3. Date established ______

4. Population of area served ______ Radius of operation ______ miles

5. Receipts (if applicable) $ ______ Number of volunteer members ______
   Number of paid members ______

6. Have you 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 years**, have any claims been presented to your current or prior insurance carrier(s)? If yes, please provide description of claim, date of loss, amount(s) paid and reserved. ______ ☐ 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. ______ ☐ Yes ☐ No

9. Has applicant, or any other person for whom coverage is being requested, had any application for liability insurance denied, policy cancelled or nonrenewed in the past (3) three years? If yes, please provide full details. ______ ☐ Yes ☐ No

A13 (09/03)

10. Type of service

- ☐ Ambulance
- ☐ First Responder
- ☐ Paramedic
- ☐ Alarm Monitoring
- ☐ Rescue Squad with ambulance
- ☐ Rescue Squad without ambulance
- ☐ Fire Dept. with ambulance
- ☐ Fire Dept. without ambulance
- ☐ Dispatch Service for others
- ☐ Other (specify) ______________

11. Number of:

Operational ambulances ______________
Stand-by ambulances ______________
Chair cars/vans/mini vans ______________
EMT's ______________
Paramedics ______________
1st responders ______________

12. Number of annual calls:

Emergency ______________
Non-emergency (ambulance) ______________
Non-emergency (transport) ______________

Do all non-emergency transp. drivers have CPR or Red Cross Lifesaving training? ☐ Yes ☐ No

13. Number of crew per ambulance

Crew	Number of crew per ambulance	Number of hours of annual training for each
EMTS-A	______________	______________
EMTS-P	______________	______________
Nurses	______________	______________
Other	______________	______________

______________ (Please describe "other" crew)

14. Current General Liability insurer: ______________

Current Auto insurer: ______________

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)

17.

Additional Insureds	Describe Interests of Additional Insureds

18.

Type of Coverage Requested	Limits of Liability Requested	Proposed Effective Date
Professional Liability		
Other		

19. Effective Dates Desired: From ______________ To ______________

Applicants signature: ______________

Title: ______________

Date: ______________

Producing agent: ______________