Member Companies of Western World Insurance Group

☐ 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 _____
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 _____

Application For **Emergency and Non-Emergency Medical Transport** *Attachment to A13*

Name of Applicant ______________________________

#	Description or Full Details