Application
For
Emergency Care Services
Professional Liability

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1. Name of applicant _____
   Street address _____
   City _____ State _____ Zip _____

2. Type of Organization ___ Volunteer ___ Individual ___ Partnership
   ___ Corporation ___ For Profit ___ Non-Profit
   ___ Municipality (fully described 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 ___ Yes ___ No
   prior insurance carrier(s)? If yes, pleas provide description of claim, date of loss,
   Amount(s) paid and reserved. _____
   _____
   _____

8. Is the applicant, or any other person for whom insurance is being requested, ___ Yes ___ No
   aware of any circumstances which may result in a claim? If yes, please provide
   full details. _____
   _____
   _____

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

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 _____ EMT's _____
Stand-by ambulances _____ Paramedics _____
Chair cars/vans/mini vans _____ 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 — 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

Applicants signature: _____
Title: _____
Date: _____
Producing agent: RISKPRO Insurance Agency, LLC

Click here to E-mail

REMEMBER to print a copy of the application before you e-mail.

You may return to us by Fax (972) 235-3556 or mail PO Box 515512, Dallas, TX 75251 or click the button above to e-mail.