QSR
Quaker Special Risk

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AMBULANCE DRIVERS AND ATTENDANTS MALPRACTICE APPLICATION

APPLICANT			
MAILING ADDRESS			
DOES THE APPLICANT OPERATE FOR PROFIT? ☐ Yes ☐ No	STATE NO. OF YRS. IN BUSINESS	NUMBER OF AMBULANCES MAINTAINED: Operational	Standby
RADIUS OF OPERATIONS	HOURS OF OPERATION	NUMBER OF CREW MEMBERS: Per Vehicle	TOTAL

ARE ALL CREW MEMBERS QUALIFIED? ☐ Yes ☐ No

QUALIFICATIONS OF CREW MEMBERS:

☐ Red Cross ☐ National Ambulance Training Institute ☐ Paramedics - State Number of Paramedics:_____ Full Time_____ Part Time_____

Other (Specify)

NUMBER OF ANNUAL CALLS (APPROXIMATELY) LAST YEAR:	ESTIMATED NUMBER THIS YEAR:
To Emergencies _____	To Emergencies _____
Transporting to and from hospitals other than Emergency Cases _____	Transporting to and from hospitals other than Emergency Cases _____

HAS ANY CLAIM FOR ERROR, OMISSION OR NEGLIGENCE BEEN MADE AGAINST YOU DURING THE PAST FIVE YEARS OR DO YOU KNOW OF ANY CIRCUMSTANCE WHICH COULD GIVE RISE TO SUCH A CLAIM?

☐ Yes ☐ No - If "Yes", give full details.

GIVE DETAILS OF PREVIOUS INSURANCE, IF ANY

HAS ANY COMPANY CANCELLED, DECLINED OR REFUSED TO ISSUE SIMILAR INSURANCE?

☐ Yes ☐ No - If "Yes", explain.

LIMITS AND EFFECTIVE DATE DESIRED:

Limits: $_____ Each Claim $_____ Annual Aggregate Effective _____

The applicant warrants and agrees that the above answers and all attachments are in all respects true and that all pertinent information has been fully disclosed. Completion of this form does not bind coverage. Applicant's acceptance of Company's quotation is required prior to binding coverage and policy issuance.

APPLICANT	TITLE	DATE
AGENCY	ADDRESS	PHONE NO.