Pennock Insurance, Inc.
2 Christy Drive, Suite 100
Chadds Ford, PA 19317
1.800.662.5182 Call
484.631.0816 Fax
pennockins.com

EMERGENCY CARE SERVICES

APPLICANT'S INFORMATION

APPLICANT NAME:			
BUSINESS NAME:			
INSPECTION CONTACT:		PHONE:	
MAILING ADDRESS:			
INSURED ADDRESS:	☐ Same as above		

☐ Corporation ☐ Individual ☐ Partnership ☐ Municipality ☐ For Profit ☐ Non-Profit ☐ Joint Venture

☐ Other_____

GENERAL INFORMATION

1. FULL description of operations:

_____

_____

2. List full names of individual or partners and their interests:

_____

_____

3. Date established: _____/_____/_____

4. Indicate applicant's professional specialty (be specific) _____

_____

_____

5. Number of volunteer members: _____ Number of Paid members: _____
Population of area served: _____ Radius of operation (mi.): _____

6.

	Number of	Number of hours of annual training for each
EMT – A		
EMTS – P		
Nurses		
Other		

7.

	Number of		Number of
EMTS		Mini Vans	
Operational		First Responders	
Ambulances		Chair Cars	
Paramedics		Emergencies Calls	
Stand By		Non-Emergencies Calls	

8. Indicate number of: Receipts $_____ Payroll $_____
Is applicant engaged in, associated with or involved in any other enterprise? ☐ No ☐ Yes
If yes, provide full details _____

9. Do you administer any anesthesia? ☐ No ☐ Yes

10. Do you contract your services to others on an independent contractor basis? ☐ No ☐ Yes
If yes, please advise to whom you contract your work. _____

11. Has applicant had previous insurance for this enterprise? ☐ No ☐ Yes – please complete the following:
Insurance Company: _____
Limits of Liability: _____
Current General Liability Carrier: _____
Does Auto Liability carrier exclude Loading & Unloading? ☐ No ☐ Yes

12. During the past five years, have claims been presented to you, your current or prior insurance carrier? ☐ No ☐ Yes
If yes, provide full details (Include description of claim, amounts paid, and reserves.) _____

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

14. Has applicant, or any other person for whom coverage is being requested, had any application for liability insurance denied, policy canceled, or nonrenewed in the past five (5) years? ☐ No ☐ Yes - please provide full details
List any Additional Interests: _____

15. Additional Comments: _____

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

_____ _____
Applicant's Signature Sub-Producer

_____ _____
Title/Date Producer

*SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed and dated to be considered for quotation.