



CERTIFICATE OF INSURANCE REQUEST

RUSH **YES** **NO**

▷ **ORGANIZATION INSURED:**

POLICY #:

LIMIT:

▷ **TYPE OF INSURANCE:**

SELECT YOUR OPTION(S)

GENERAL LIABILITY

PROPERTY

HOSPITAL PROPERTY

AUTOMOBILE

EXCESS LIABILITY

WORKERS COMPENSATION

▷ **CERTIFICATE HOLDER:**

ORGANIZATION:

ADDRESS:

CITY:

STATE:

ZIP CODE:

CONTACT NAME:

PHONE NUMBER:

▷ **EVENT LOCATION:** *(IF DIFFERENT FROM CERTIFICATE HOLDER)*

ADDRESS:

CITY:

STATE:

ZIP CODE:

▷ **ACTIVITY REQUIRING CERTIFICATE:**

BEGINNING DATE (MM/DD/YYYY):

ENDING DATE (MM/DD/YYYY):

ADDITIONAL INSURED:

YES

NO

SPECIFIC WORDING REQUIRED:

SPONSORED BY:

▷ **NEEDED FOR PROPERTY / EQUIPMENT**

VALUE:

SERIAL#:

MODEL#:

LOAN #:

PLEASE EMAIL CERTIFICATE OF INSURANCE TO: *USE A SEMICOLON TO SEPARATE E-MAIL ADDRESSES IN CASE YOU NEED TO SEND A COPY OF THE CERTIFICATE OF INSURANCE TO MULTIPLE RECIPIENTES*

PLEASE NOTE: CERTIFICATES WILL NO LONGER BE ISSUED BY FAX OR MAIL. PLEASE PROVIDE E-MAIL ADDRESSES OF ANYONE NEEDING TO RECEIVE A COPY OF THE CERTIFICATE.

COMMENTS:

▷ **REQUESTED BY:**

DATE (MM/DD/YYYY):

SELECT YOUR CUSTOMER SERVICE REPRESENTATIVE: