REQUEST FOR CERTIFICATES OF INSURANCE

DATE: ______________________________________________________________________

PARISH/SCHOOL NAME: __________________________ CITY: ________________

LEDGER PAGE NO.: __________________

NAME OF ENTITY REQUESTING CERTIFICATE: ________________________________

COMPLETE ADDRESS: ______________________________________________________

_________________________________________________________________________

EVENT: _________________________________________________________________

DATE OF EVENT: _______________________________________________________

LOCATION OF EVENT: _____________________________________________________

**IS THERE AN AGREEMENT OR CONTRACT?  □ YES □ NO /IS IT AVAILABLE? □ YES □ NO

(IF YES, PLEASE ATTACH; IF NO, PLEASE SEND LETTER FROM THE ENTITY REQUESTING
THE CERTIFICATE, WHICH STATES THEIR INSURANCE REQUIREMENTS)

**DO THEY NEED TO BE NAMED ADDITIONAL PROTECTED PERSON(S)? □ YES □ NO

LIMITS OF COVERAGE REQUESTED/REQUIRED: ________________________________

(Insert dollar amount)

MAIL ORIGINAL TO: ___________________________________________________________________

COPIES TO: __________________________________________________________________________

** MUST BE ANSWERED

Please complete and mail or fax to:
Catholic Mutual Group
ATTN: Kris Twining
702 South High Point Rd, Suite 221
Madison, WI 53744-4983
(608) 821-4566 Phone
(608) 833-3794 Fax