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 ADDITONAL 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
P.O. Box 44983
Madison, WI 53744-4983
(866) 833-3090 Phone
(608) 833-3794 Fax