

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