HIRE QUEST

SPECIAL REQUIREMENTS CERTIFICATE OF INSURANCE REQUEST FORM

DATE: _____

BRANCH: _____

CERT HOLDER: _____
Additional Insured Person(s) Organization(s)

ADDRESS: _____

_____

_____

FAX: _____

_____

FAX/EMAIL ( ) _____
WORKERS COMP CERTIFICATE *ONLY*

JOB DESCRIPTION: **(Please include Project Name and Address. Must be Specific with description)**

_____

_____

_____

ESTIMATED ANNUAL PAYROLL: _____

ADDITIONAL INSURED: _____ $100.00

CG 2037: **(Please allow 5-10 Business Days to Process)** _____ $250.00 per Jobsite
(ONLY APPLIES TO GENERAL LIABILITY)

WAIVER OF SUBROGATION:

GENERAL LIABILITY _____ $100.00

WORKERS COMPENSATION _____ N/C

ALTERNATE EMPLOYER ENDORSEMENT: $200.00
(ONLY APPLIES TO WORKERS COMPENSATION) _____

WC CLASS CODE _____

_____

REQUESTED BY:

DATE:

*********PLEASE ALLOW 3 - 5 DAYS TO PROCESS CERTIFICATES********