**CONSOLIDATED CATHOLIC ADMINISTRATIVE SERVICES, INC.**

**CERTIFICATE OF INSURANCE REQUEST FORM**

If your organization is using a facility for its activities, the facility/lessor *may* request a Certificate of Insurance. If the facility requests a Certificate of Insurance from your group, you will need to request one by uploading this completed form to your event application.

Please enter the information below. Please note the following regarding the Insured’s Name:

* The Insured’s Name is the legal name of the entity organizing the event, such as *RC Activities, Inc.* (which is the default name below) or change the organizing entity name *to Our Lady of Santa Clara, Legion of Christ College,* etc…
* The insured name is the entity organizing the event, which is the entity that receives registration funds for this event.

*Note: Please tab between fields to complete this form.*

Insured’s Name: *RC Activities, Inc.*

Insured’s Address: *Enter the Address*

City: *Enter City*  State: *Enter State* Zip*: Enter Zip Code*

Your Name: *Enter Your Name*

Your Telephone: *Enter Your Phone Number*

Your E-mail: *Enter Your Email Address*

**CERTIFICATE INFORMATION**

Coverages needed on Certificate:

\_\_**X**\_\_GENERAL LIABILITY

Limits requested by facility: *Enter the annual coverage amount requested by the facility. Generally, this is $1,000,000.*  Additional Amount: *Enter additional aggregate amount if requested*

Certificate Holder: *Enter the owner of the facility*

Facility Name*: Enter the Facility Name*

Address: *Enter the Facility Address*

City: *Enter City* State: *Enter State* Zip: *Enter Zip Code*

Facility Contact Name: *Enter Facility Contact’s Name*

Telephone: *Enter Facility Contact’s Phone Number* Fax: *Enter Facility’s Fax Number*

E-mail: *Enter the Facility Contact’s Email Address*

**Certificate Holder’s Interests (check box for one item below as requested by facility, *NONE* if no requests other than proof of insurance):**

*Note: Click the correct box to select the type*

CERTIFICATE HOLDER ONLY ADDITIONAL INSURED NONE

**Reason for Certificate of Insurance:**

USE OF FACILITIES PROOF ONLY

Please provide event dates and description, if applicable: the

Additional Insured name/Loss payee name: (If additional insured language is requested, the contract or facility use agreement must be provided)

*Enter the names of requested additional insured if required as listed on the facility agreement.*

For any questions regarding this form, please contact:

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855-556-6872 ext 1