

# REGION 15 AHA INSURANCE REQUEST

ACTIVITY NAME \_\_\_\_\_

DATE(S) \_\_\_\_\_

LOCATION (STREET ADDRESS) \_\_\_\_\_

IDENT. NUMBER (if provided) \_\_\_\_\_

OTHER NUMBERS/ORGANIZATIONS AS NEEDED \_\_\_\_\_

EVENT MANAGER NAME/ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_ E-mail \_\_\_\_\_

ADDITIONAL INSUREDS (GROUNDS OR BUILDING OWNER AS REQUIRED) \_\_\_\_\_

Please send Certificate of Insurance to (also please include fax number if available):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE SEND REQUEST AT LEAST 60 DAYS PRIOR TO EVENT TO INSURE  
COVERAGE HAS BEEN CONFIRMED**

SEND COMPLETED FORM TO:

Wayne Gavitt RR 1Box 1023, Forksville, PA 18616