

Due with Submission

Insured Name: _____

Please provide complete information for each location covered by the policy. For EXAMPLE:

St Mary's Hospital	123 Main St	Springfield	IL	62306	400	250	10,783,200
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EXAMPLE

Insured Identification	Insured Address				# of Employees		Other Items
<u>Insured Name</u>	<u>Street Address</u>	<u>City</u>	<u>State</u>	<u>ZIP Code</u>	<u>Total at Location</u>	<u>MAX per Shift</u>	<u>Estimated Payroll</u>