Due with Submission

Insured Name: ______________________________

Please provide complete information for each location covered by the policy. For EXAMPLE: **EVEN IF NO EMPLOYEES!!!**

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

Each state that is wanting coverage must have a location

Insured Identification	Insured Address				# of Employees		Other Items	FEIN #	Phone #
Insured Name	Street Address	City	State	ZIP Code	Total at Location	MAX per Shift	Estimated Payroll		