



CERTIFICATE REQUEST

Submit this completed form by:

1. Fax to 601.707.1019
2. Email to ktucker@sportsfitness.com
3. Mail to PO Box 1967, Madison, MS 39110

Date of Request: _____

Insured's Name: _____

Phone Number: _____

Policy Number (must be included): _____

Additional Insured Name and Address: _____

Other Changes: _____

\$25.00 for each additional insured

CREDIT CARD INFORMATION

NOTE: By selecting to pay with a credit card, a convenience fee of 2% will be added to your invoice except in Colorado, Connecticut, Florida, Kansas, Maine, Massachusetts, and Oklahoma.

Mastercard Visa Discover Check (Mail In)

Number: _____ Security Code: _____ Expiration Date: _____

Please include how you would like this returned to you.

Email: _____

Fax: _____

Mail: Yes No

Signature of Applicant

Date