

TRI EVIDENCE OF INSURANCE REQUEST

(please allow 45 days for processing)

DATE: _____

Dear TRI Leader.

Please complete this form only when the facility, agency, or owner, where you are holding the event, requires a Certificate of Insurance (Evidence of Insurance). This form must be filled out by the Leader planning the event. The second page of this form must be filled out by the facility, agency, or owner. (It is recommended that you photocopy the second page and leave it with them to be completed! When both forms are completed, send them and the appropriate check to the Business Office for processing.

If either of the two pages are not filled out properly, they will be returned. Please note, we need a minimum of 45 days to process your request. You do not want to risk having your event without the proper insurance coverage. If the facility does not wish to fill out the form, we will accept a letter, on their official letterhead, listing whom the Additional Insureds should be—EXACTLY.

If you have any questions, call Member Services at 1-800-843-9460.

(Remember to print your name and phone number on page 2 before giving it to the facility.)

Leader requesting approval (<i>Please print</i>):	
Name: _____	Position: _____
Address: _____	
City: _____	State: _____ Zip: _____
Phone: () _____ Day	
Activity Description & Purpose: _____	

Dates of Activity: _____	
Location of Activity: _____	
Event Registration Fee (if any): _____	

Name of Group: _____	

BUSINESS OFFICE USE ONLY	
Date Received: _____	

Date Cert. Mailed: _____
Ins. Contact: _____
Ck. Amt.: \$ _____
Ck. Number: _____
Processor's Init: _____
Special Note: _____

If Evidence of Insurance is required, remit \$50 for Revenue generating events.
Public Relation events \$10.

Both forms must be received at Business Office 45 days prior to event!

(Evidence of Insurance Request - Page 2)

Requesting Facility To Fill Out This Section

Facility requesting evidence of insurance:

Contact Name:

Title: _____

Business Name: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Business Phone: _____ FAX: _____

Additional Insureds (please list exactly as needed)

Signature

Date

Please return this form to the TRI Leader who has requested it.
Thank you for your assistance.

TRI Leader's Name: _____

Phone number: _____

Trike Riders International Organization

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Phoenix, Arizona 85080-2450
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