



RPG Policy Change/Certificate Request Form

TO AVOID PROCESSING DELAYS, PLEASE:

1. Complete all sections (print legibly)
2. Remit completed request form to us

Please retain a copy of this form for your records.

Today's date: ____/____/____

Effective date of change: ____/____/____

GENERAL INFORMATION

Named insured (as it appears on your certificate of insurance): _____

Policy number (as it appears on your certificate of insurance): _____

Contact name: _____ Phone: (____) _____

Cell: (____) _____ Fax: (____) _____

E-mail: _____

Please indicate the type of change needed and complete the appropriate section.

Note: Some changes may result in an increase of premium due and will be effective the day after receipt or a later date.

- | | |
|--|--|
| <input type="radio"/> Cancel coverage | <input type="radio"/> Limit of coverage |
| <input type="radio"/> Cancel/change event date | <input type="radio"/> Mailing address |
| <input type="radio"/> Certificate amendments and/or requests | <input type="radio"/> Named insured |
| <input type="radio"/> Contact name | <input type="radio"/> Phone, fax and/or e-mail |
| <input type="radio"/> Facility location | <input type="radio"/> Type of operation |
| <input type="radio"/> Other (please explain): _____ | |

GENERAL REQUESTS

Cancel Coverage

Effective date of cancellation: ____/____/____ (Note: coverage can not be cancelled prior to our receipt of this form)

Reason for cancellation: _____

Cancel/Change Event Date

Effective date of cancellation/change: ____/____/____ (Note: request must be received prior to or on the day of event)

Reason for cancellation/change: _____

Facility Location Change

Replace facility location Add new facility location

Address: _____

City: _____ State: _____ Zip: _____

New facility square footage: _____

Was there a change in the insured's annual sales? Yes No

 If yes, please provide revised annual sales: \$ _____

Did membership change? Yes No

 If yes, please provide revised membership number: _____

Do you currently have Sexual Abuse or Sexual Molestation Liability Coverage with us? Yes No

GENERAL REQUESTS CONTINUED

Limit of Coverage

Type of coverage:
Current limit: \$
New limit requested: \$
Do you currently have Sexual Abuse or Sexual Molestation Liability Coverage with us? Yes No

Named Insured, Contact Name, Mailing Address, Phone, Fax or E-mail Change

Named insured:
Mailing address:
City: State: Zip:
Contact name: E-mail:
Phone: () Fax: ()

Type of Operation

Please provide the type of change:

Other

Please explain/describe change:

MAILING INSTRUCTIONS

Submit change request submission to us.

- E-mail: KK_MassMerchandising@kandkinsurance.com
Mail

Regular: K&K Insurance Group, Inc. MM RPG Programs P.O. Box 2338, Fort Wayne, IN 46801-2338
Overnight: K&K Insurance Group, Inc. MM RPG Programs 1712 Magnavox Way, Fort Wayne, IN 46804

Note: If a certificate of insurance is needed for this change request, please proceed to page 3 and include this with the change request submission.

DOCUMENT DELIVERY

This coverage document will be delivered via e-mail, unless otherwise indicated below. If you have an insurance agent, all documents will be delivered to your agent only. Additional certificate requests will be issued to the same person. Please select only one option.

- E-mail to: attn:
Fax to: attn:
Mail to: attn:

FOR K&K USE ONLY

Rec: / / Policy #: Cert #: Insured #:
Quote: / / Bound: / / Opt: Premium: \$
Eff/Exp: / / to / / Opt form: 2026 2011 2404 8016 8018 876
Delivery: M F E Date: / / Comments:

CERTIFICATE REQUEST

Complete this section to request a new certificate.

Provide separate requests for each additional certificate needed.

- This is a Change/amendment to a certificate already issued (please attach a copy of the certificate)
 New certificate request

Need by date for certificate: _____ / _____ / _____

This certificate is for our:

- Program coverage (commercial general liability) Equipment and contents coverage

Check the type of certificate you are requesting:

- Additional insured Evidence of coverage Loss payee

Certificate holder information:

Entity name: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Relationship to named insured:

- Owner/lessor of premises Sponsor Co-promoter Mortgagee
 Franchisor Lessor of equipment and contents Event organizer
 Other (please identify/explain): _____

Special certificate language needed (please explain/attach): _____

- Primary Waiver of subrogation Cancellation - _____ days

If applicable:

RE: Date(s) of event/activity: _____ / _____ / _____ to _____ / _____ / _____

Hours of the event/activity: _____ A.M. / P.M. to _____ A.M. / P.M.

Type of event/activity: _____

Name of event/activity: _____

Location of event/activity: _____

PAYMENT INFORMATION

100% of the premium is due upon receipt of this supplemental.

- Check:** Please make check payable to K&K Insurance Group, Inc. Enclosed is check # _____ for \$ _____
 Credit Card: If you are making your payment by credit/debit card, please complete the following:
 VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Card number: _____

CSC # (card security) code: _____ Expiration date: _____

I authorize K&K Insurance Group, Inc. to charge my payment to my credit card in the amount of \$ _____

Print name (as on card): _____

Cardholder signature: _____