Liability Insurance Application

To avoid delays in processing, please type or print legibly. Please complete all fields.

Affiliate Name (Chapter or State Organization)

Affiliate Name: ____

Contact Name: ____

Affiliate Address: ____

City, State, Zip: ____

Phone: ___________________________Email: ______________________________

Event Information

For each event/meeting(s) location please provide the following information.

Name of Event: ____

Date(s) of Event/meetings: ____

Event Address: ____

City, State, Zip: ____

Estimated Number of Participants: ____

Name of Landlord or Property Manager: ____
(Person who is requesting the certificate of coverage)

Company: ____

Mailing Address: ____

City, State, Zip: ____

Phone: ____Fax: ______________________________

Email: ____

Make check payment of $25 payable to HLAA and send to the address noted below. Please note in the memo area of the check that it is for Liability Insurance.

Mailing Address:	Questions - Call/Email
Hearing Loss Association of America 6116 Executive Blvd., Suite 320 Rockville, MD 20852	Phone: 301.657.2248 chapters@hearingloss.org

Revised 1.2021