# 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.**

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| Mailing Address:Hearing Loss Association of America7910 Woodmont Ave., Suite. 1200Bethesda, MD 20814 | Questions - Call/EmailPhone: 301.657.2248chapters@hearingloss.org |

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