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: Hearing Loss Association of America 7910 Woodmont Ave., Suite. 1200 Bethesda, MD 20814	Questions - Call/Email Phone: 301.657.2248 chapters@hearingloss.org

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