CITY OF COLLINSVILLE

INSURANCE VERIFICATION FORM

Name of Insured _____

Telephone _____ FAX _____

Address _____

City _____ State _____ Zip _____

Contractor Federal/ State Employer Identification Number (EIN)

Worker's Compensation Information

Name of Insured: _____

Telephone: _____ Contact Person: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy No. _____ Amount of Coverage: _____

Policy Effective Date: _____ Policy Expiration Date: _____

General Liability Information

Name of Insured: _____

Telephone: _____ Contact Person: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy No. _____ Amount of Coverage: _____

Policy Effective Date: _____ Policy Expiration Date: _____