

REQUEST FOR MR/LD INSURANCE SPECIAL CERTIFICATE

Council # _____ Council Name: _____ Date of Drive: _____

Send to: _____ Address: _____

City _____ St ____ Zip Code _____ Phone # _____

Email: _____ Fax # _____

Name of Certificate Holder	Name of Additional Insured/Special Language
#1 Name	
Address	
City, St Zip	
#2 Name	
Address	
City, St Zip	
#3 Name	
Address	
City, St Zip	
#4 Name	
Address	
City, St Zip	
#5 Name	
Address	
City, St Zip	
#6 Name	
Address	
City, St Zip	
#7 Name	
Address	
City, St Zip	
#8 Name	
Address	
City, St Zip	

Mail to:
Illinois State Council K of C Charities Inc
PO Box 681
Kankakee, IL 60901
FAX 815-935-2262
illinoiskc@illinoisknights.org