CHIROPRACTIC MANAGEMENT SERVICES, LLC (CMS LLC)

REQUEST FOR CERTIFICATE OF INSURANCE and CLAIMS HISTORY INFORMATION
As a Certificate Holder

TO:

_____
Name of Insurance Company

_____
Address **City** **State** **Zip**

RE:

_____
Name of Insured **Policy Number**

_____
Office Address **City** **State** **Zip**

I, the above named insured, authorize and request the above named insurance company to provide to CMS LLC, at the address below, a certificate of insurance verifying my professional liability insurance coverage and including my policy number, expiration date, and coverage limits, as well as my medical malpractice claims history report for no less than the last five (5) years. With this, I authorize CMS LLC to be listed as a certificate holder.

_____ _____
Signature of insured **Date**

CMS, LLC
19435 W. Capitol Drive
Suite 103
Brookfield, WI 53045-2738
Fax: 262-547-4472

Note: This letter must forwarded to CMS LLC and your insurance carrier simultaneously.