

## 2010 WDCTA PUBLIC DAY INSURANCE REQUEST FORM

Chapter:		Date:	
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Event Name:			
Date(s) of Event:			
Location:	Phone:		
Event Manager:	Phone:		
Address:			

Is this event USA Equestrian Sanctioned?	Yes		No	
Do you need a Certificate of Insurance?	Yes		No	
Must anyone other than WDCTA be listed as Insured?	Yes		No	

If yes, please give complete name and address of Additional Insured:

Total Number of Days of Clinic OR Show:		at \$42 per day =	\$
Number of Additional Insureds:		at \$28 each =	\$
Total Cost of Insuring This Event:			\$
Subtract Amount Remaining of Chapter's Annual \$100 Insurance Allowance:			-
TOTAL ENCLOSED:			\$

Please make checks payable to **WDCTA**.

Please list names of each person to whom you expect to pay in conjunction with this event (e.g., judges or clinicians):

Mail with payment **and copy of participant release form** to:

Angela Genin  
WDCTA Treasurer  
498 Cledell St #3  
Oregon, WI 53575  
608-516-2293

This completed form and payment in full must reach the WDCTA treasurer at least three weeks prior to the date(s) of the event. The day before and the day after the event is automatically included in the basic premium. Please include the complete address and phone numbers for the location and event manager. If you requested a Certificate of Insurance, it will be mailed to the event manager or additional insured.

For Treasurer's Use Only:

Date Received	Amount	Check #	Date Sent	Amount	Cert. Received