



## WAIVER OF SUBROGATION INFORMATION REQUEST

Please submit this form along with a copy of your Certificate of Insurance Request Form AND A COPY OF THE CONTRACT REQUESTING THE WAIVER. Fax to 804-934-9790

INSURED/MEMBER NAME: \_\_\_\_\_

POLICY/MEMBER #: \_\_\_\_\_ Effective Date of Waiver: \_\_\_\_\_

CERTIFICATE HOLDER NAME AND ADDRESS REQUESTING THE WAIVER:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CONTRACT OR PROJECT NUMBER: \_\_\_\_\_

CONTRACT OR PROJECT LOCATION (include street address and state):

\_\_\_\_\_  
\_\_\_\_\_

JOB DESCRIPTION: \_\_\_\_\_

\_\_\_\_\_

START/COMPLETION DATES: \_\_\_\_\_

PROJECTED LENGTH OF JOB: \_\_\_\_\_

Codes      Payrolls      # Employees (FT/PT)      Location

\_\_\_\_\_  
\_\_\_\_\_

**\*PLEASE NOTE:** All payroll records for the job carrying the waiver must be kept separately for premium audit purposes.