

Additional Benefit Holder Form

Fax Form to: 1-800-871-3848
Or **Email** Form to: Support@AlternativeBalance.org
Or **Mail** Form to: Alternative Balance llc , Po Box 450 Hillsboro, NH 03244

*This form is for Current Members looking to add an additional insured to their current policy/membership.
If you are not a member please add your additional insured on your application. Thank you.

Additional Benefit Holders

Your membership will provide you with insurance as an individual only.

Often your landlord or place of work such as a salon, spa healthcare center, hotel and or resort or tradeshow require that they be listed on your certificate of Insurance as an Additional Benefit Holder specifically for your work. If this is the case simple complete the detailed information below.

You may also choose to list your company name as the additional insured.

The Additional Benefit Holder is not for other professional providers as they must have their own individual policy.

There is a \$10 charge for each additional insured. Paid to: Alternative Balance LLC

Additional Insured Benefit Holder #1

Additional Insured : _____
Mailing Address: _____
City: _____ State: _____
Zip: _____ Country: _____
E-mail: _____
Website: _____
Phone (Home) (____) _____
Business: (____) _____
____ Landlord ____ Employer ____ Trade Show
____ Other please list _____

Additional Insured Benefit Holder #2

Additional Insured : _____
Mailing Address: _____
City: _____ State: _____
Zip: _____ Country: _____
E-mail: _____
Website: _____
Phone (Home) (____) _____
Business: (____) _____
____ Landlord ____ Employer ____ Trade Show
____ Other please list _____

Additional Insured Benefit Holder #3

Additional Insured : _____
Mailing Address: _____
City: _____ State: _____
Zip: _____ Country: _____
E-mail: _____
Website: _____
Phone (Home) (____) _____
Business: (____) _____
____ Landlord ____ Employer ____ Trade Show
____ Other please list _____

Member Information (MUST BE COMPLETED)

Name: _____
Mailing Address: _____
City: _____ State: _____
Zip: _____ Country: _____
E-mail: _____
Website: _____
Phone (Home) (____) _____
Policy/ Account # _____

Payment

*A \$25 Charged will be assessed on all returned checks. Fee's must be paid in U.S. dollars. All fees paid to **Alternative Balance** are non-refundable once your application is accepted.

____ Check/Money Order ____ Visa/MasterCard ____ Discover ____ Amex

Name on Card: _____
Billing Address for Card: _____
City: _____ State: _____ Zip: _____
Card # _____
Exp. Date: ____/____/____ CVN (Required) _____
CVN is the last 3 Digits on the back of the card for Visa/MC/Disc & 4 Digits in the front of AMEX

Request Confirmation to:

(please specify where you would like your updated certificate sent)

Email: _____

Fax to: (____) _____