The GW Medical Faculty Associates

REQUEST FOR CERTIFICATE OF INSURANCE (COI)

Name of provider, including designation (please print):

____

Dates of employment at MFA: ____
If you are a resident, please indicate the dates of residency

Department /Title: ____

Contact information:

Email: ____

Telephone: ___________________________ Fax:_____________________________

Address: ____

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How do you wish to be contacted? ☐ Email ☐ Telephone ☐ Fax ☐ U.S. Mail
If you choose email, please ensure that the email address provided above is valid

I acknowledge and understand that the COI reflects only the status of the policy when the COI is issued and is not a guarantee that the policy will remain active throughout the policy period specified.

Signature of provider/requestor: ____

Date: ____

Please email this form to: MFA-Office of the General Counsel- Risk Management
insurance@mfa.gwu.edu

For claims history request, please complete a claims history request form and attach any documents with the specific language containing the claims history question.