Please email to endorsements@roofersalliancewc.com or fax to (916) 797-5357

AUTO INSURANCE VEHICLE ADD

MAKE SURE TO COMPLETE ALL INFORMATION IN ORDER TO HAVE THE ENDORSEMENT BE COMPLETED.

INSURED'S NAME: _____

AUTO INSURANCE POLICY #: _____

VEHICLE YEAR, MAKE, MODEL: _____

VIN #: _____

COVERAGE'S REQUESTED: Liability Uninsured Motorist Med Pay
Comprehensive Collision

VEHICLE YEAR, MAKE, MODEL: _____

VIN #: P_____

COVERAGE'S REQUESTED: Liability Uninsured Motorist Med Pay
Comprehensive Collision

VEHICLE YEAR, MAKE, MODEL: _____

VIN #: _____

COVERAGE'S REQUESTED: Liability Uninsured Motorist Med Pay
Comprehensive Collision

VEHICLE YEAR, MAKE, MODEL: _____

VIN #: _____

COVERAGE'S REQUESTED: Liability Uninsured Motorist Med Pay
Comprehensive Collision