RESPITE Program Insurance Application

Please complete this form and return (along with payment) to the NCCW office. This information will be submitted to the CIMA Insurance Company.

RESPITE GROUP: ______________________________

CONTACT: ______________________________

ADDRESS:

____

Street City State Zip Code

TELEPHONE: ______________________________

Names of Volunteer(s)	Address

TOTAL AMOUNT OF CHECK: $__________ ($3.00 PER VOLUNTEER)
USE ADDITIONAL PAPER IF NECESSARY.
Mail to:

National Council of Catholic Women, c/o Respite Insurance
200 North Glebe Road, Suite 725, Arlington, VA 22203.

THIS AREA IS FOR NCCW USE ONLY. PLEASE DO NOT WRITE BELOW.

Check Number:__________ Amount:_________ Date of Check:________ # of Volunteers:______