



**DOCTORS'  
ARMOR**  
by Physicians Indemnity

## REQUEST TO ADD A CERTIFICATE HOLDER

*Please complete one form for each Certificate Holder being requested.*

Policyholder Name: \_\_\_\_\_

Current Policy Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Please provide the Certificate Holder information.

Add    Change    Delete

Name Certificate Holder: \_\_\_\_\_

Administrative Contact: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Cancellation Notice - Number of Days Required: \_\_\_\_\_

*(If unknown, please leave blank. If blank, PIRRG will provide ten (10) days' notice.)*

Do you want Doctors' ARMOR to send the COI to Certificate Holder:  Yes or  No

Policyholder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return the completed form via email ([info@pirrg.com](mailto:info@pirrg.com)) or fax (888-608-6327)**

**3902 Flatiron Loop, Suite 101 | Wesley Chapel, Florida 33544  
T: 813-513-3041 | F: 888-608-6327**

[www.doctors-armor.com](http://www.doctors-armor.com)