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**HMS Insurance Associates, Inc.**  
20 Wight Avenue, Suite 300  
P.O. Box 1750  
Cockeysville, MD 21030  
www.hmsia.com

## EQUIPMENT CHANGE REQUEST FORM

Attn: \_\_\_\_\_

Named Insured: \_\_\_\_\_

Requested by: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Add: \_\_\_\_ Delete: \_\_\_\_ Lease: \_\_\_\_ # of Days/Months: \_\_\_\_\_

Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_

Serial Number #: \_\_\_\_\_

Value: \_\_\_\_\_

Additional Insured/Loss Payee Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Certificate of Insurance: Yes \_\_\_\_\_ No \_\_\_\_\_

*\* Please note that no coverage changes will be in effect until you receive confirmation from an HMS representative.*

*\* Please contact our office if confirmation of this request is not received within 5 days.*