Árachas Group
INSURANCE
keystone platform partner

CERTIFICATE REQUEST

DATE: _____ REQUESTED BY: _____

INSURED:_____

CERTIFICATE HOLDER: NAME:_____

ATTN:_____

ADDRESS:_____

_____

VEHICLE DESCRIPTION:_____

MISCELLANEOUS:_____

_____

_____

DOES THIS CERTIFICATE NEED TO BE FAXED? ____YES ____NO

FAX NUMBER:_____

COMMENTS:_____

_____

_____

PLEASE SUBMIT THIS FORM TO YOUR CUSTOMER SERVICE REPRESENTATIVE OR TO CERTIFICATES@ARACHASGROUP.COM OR VISIT OUR WEBSITE FOR 24/7 CERTIFICATE REQUESTS. ANY CERTIFICATE REQUEST RECEIVED AFTER 4:00 PM CT MAY NOT BE COMPLETED UNTIL THE NEXT BUSINESS DAY.