ENCOVA EDGE SYSTEM ADMINISTRATORS FORM FOR INSUREDS

SECTION 1

Insured legal name	FEIN
Authorized insured representative name	
Phone number	Email address

SECTION 2

I agree to notify Encova Insurance immediately in the event an individual appointed to act as system administrator terminates employment with my company or is no longer authorized by my company to act as a system administrator. I further understand that the system administrator(s) will have access to all information Encova makes available to my company through Encova Edge, including claim and policy information.

Signature of authorized insured representative	Date

SECTION 3

Name of system administrator	
Address	
Phone number	Fax number
Email addresss	
Select only one access option below, and provide the FEINs for that System Administrator access role. ☐ Full access ☐ Limited access	
Name of system administrator	
Address	
Phone number	Fax number
Email address	
Select only one access option below, and provide the FEINs for that System Administrator access role. ☐ Full access ☐ Limited access	

For more than two system administrators, please attach additional copies of this page.

Please fax or mail the completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Fax: 877-898-6980

encova INSURANCE