

ENCOVA EDGE SYSTEM ADMINISTRATORS FORM FOR INSURED

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 address	
	Select only one access option below, and provide the FEINs for that System Administrator access role. <input type="checkbox"/> Full access <input type="checkbox"/> 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. <input type="checkbox"/> Full access <input type="checkbox"/> Limited access	

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

Please mail, fax or email the completed form to:

Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Fax: 877-898-6980
Email: encovaedgeaccess@encova.com

