



**ACCA LIABILITY SELF-INSURANCE FUND, INC.  
ACCA LSIF-PROPERTY PROGRAM**

FAX: 334-394-3244  
[underwriting@countyrisk.org](mailto:underwriting@countyrisk.org)



**LIABILITY ENDORSEMENT POLICY CHANGE  
REQUEST**

Date: \_\_\_\_\_ Fund Member: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Fax: \_\_\_\_\_

Effective date of transaction: \_\_\_\_\_

**Professional Healthcare Svcs Provider-NO DOCTORS: *Attach a current copy of the contract, license, certifications, & certificates of insurance.***

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Type of Provider:  Contractor  Employee

Name/Title: \_\_\_\_\_

Location: \_\_\_\_\_

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**Professional Healthcare Svcs Provider-NO DOCTORS: *Attach a current copy of the contract, license, certifications, & certificates of insurance.***

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Type of Provider:  Contractor  Employee

Name/Title: \_\_\_\_\_

Location: \_\_\_\_\_

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List any additional information below:

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(Print and complete additional forms if needed)  
**EMAIL TO: [underwriting@countyrisk.org](mailto:underwriting@countyrisk.org)**