PROOF OF INSURANCE VERIFICATION FORM

We, the undersigned entity, hereby testify that proof of insurance for our organization is on file with the North Carolina Department of Health and Human Services (DHHS), and is accurate and the coverage is up to date. If coverage changes at any time during the contract period, we will submit a new Proof of Insurance letter to the Department (DHHS).

Name of Organization	
Contractor's Authorized Agent	Date
Printed Name of Contractor's Authorized Agent	Title
Signature of Witness	Date
Printed Name of Witness	Title