Print Form

CERTIFICATE OF ACTIVATION REQUEST

Account # _____

Premise Account Information

Account Holder Name: _____

Account Address: _____

Account City: _____ State: _____ Zip: _____

Account Phone Number: _____

Mailing Information (IF DIFFERENT THAN ACCOUNT ADDRESS)

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

I would like a copy of my Certificate of Activation to be faxed to my insurance company. **INITIAL** _____

Insurance Company Information

Insurance Company Name: _____

Insurance Company (Attention To): _____

Insurance Company Fax Number: _____

Account Holder Signature: _____ **Date:** _____

Please Send To:
Certified Alarm Technicians Inc. • 1401 Neptune Drive • Boynton Beach, FL 33426
Fax: 561-752-3033 • Email: service@certifiedalarmtechnicians.com
Please call to verify receipt of form • 561-752-5555
Fl.Lic. # ECA002282

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