

Information:

Drawer: Accounts Payable - Invoices  
Vendor Number: 1082122  
Vendor Name: Arthur J Gallagher Risk Management Serv  
Invoice Number: 5279528  
Invoice Date: 9/10/2024  
PO Number:  
Check Number: 0330256  
Check Amount: \$ 4,520.46  
Check Date: 09/24/2024  
Voucher Number: V0850583  
Document Type: AP Invoice

Document Below

## Check Request Form

This form may be used to request check payments only for those items for which the issuance of a purchase order would not be appropriate. Attach supporting documentation (e.g., invoice or agreement). Please refer to Administrative Procedure 2.21, Vendor Payment.

Date: \_\_\_\_\_ Vendor ID: \_\_\_\_\_ Vendor Name: \_\_\_\_\_

Payee Address: \_\_\_\_\_ Payment Due Date: \_\_\_\_\_

Invoice Number	GL Account number(s) e.g. 01-80-00757-5401001	GL Account Name e.g. Office Supplies	Amount
<b>Total</b>			<b>\$</b>

Check the appropriate box below:

- ☐ We, the undersigned, hereby certify that the goods/services, for which payment is herein requested, have been provided in a satisfactory condition/manner. Consequently, payment is appropriate at this time.
- ☐ We, the undersigned, hereby certify that the goods/services, for which payment is herein requested, have not yet been provided. The first approver indicated below will notify the Accounts Payable Office in writing when the goods/services have been delivered in a satisfactory condition/manner.

Description on Check:

Other Instructions:

### All requests will require the following approvals:

Requester: \_\_\_\_\_ Print Name: \_\_\_\_\_

Budget Officer: \_\_\_\_\_ Print Name: \_\_\_\_\_

Requests \$10,000 and over will require the additional approvals below:

Next Level Supervisor (if applicable): \_\_\_\_\_ Print Name: \_\_\_\_\_

Next Level Supervisor (if applicable): \_\_\_\_\_ Print Name: \_\_\_\_\_

Next Level Supervisor (if applicable): \_\_\_\_\_ Print Name: \_\_\_\_\_

Area Administrator (only required if request is \$10,000 and over): \_\_\_\_\_ Print Name: \_\_\_\_\_

Area Cabinet Officer (only required if request is \$25,000 and over): \_\_\_\_\_ Print Name: \_\_\_\_\_

Board Approval Date (only required if request is \$25,000 and over): \_\_\_\_\_

**Return approved request and all supporting documentation to Accounts Payable (SRC 2132A), [invoicing@cod.edu](mailto:invoicing@cod.edu)**

Gallagher Student Health & Special Risk - GAIS, Inc  
Quincy, MA 02171  
Phone:

SEQYO1

Invoice #	5279528	1 of 1
ACCOUNT NUMBER	DATE	
COLLOFD-08	9/9/2024	
BALANCE DUE ON	AMOUNT DUE	
9/9/2024	\$4,520.46	

College of DuPage  
425 Fawell Boulevard  
Glen Ellyn, IL 60137



Student Accident	PolicyNumber:	GLMN1866043A	Company:	ACE American Insurance Company	Effective:	4/15/2024 to 4/15/2025
Item #	Trans Eff Date	Due Date	Trans	Description	Amount	
35582909	4/15/2024	9/9/2024	RENB	Study Abroad	\$4,520.46	
Total Invoice Balance:					\$4,520.46	



Please return this portion with your payment. Include your invoice number on your remittance to expedite processing.

SEQYO1

College of DuPage  
425 Fawell Boulevard  
Glen Ellyn, IL 60137

Invoice #	5279528
ACCOUNT NUMBER	DATE
COLLOFD-08	9/9/2024
BALANCE DUE ON	AMOUNT DUE
9/9/2024	\$4,520.46
AMOUNT PAID	

Please send your remittance to:

Gallagher Student Health & Special Risk - GAIS, Inc  
PO Box 74715  
Chicago, IL 60694-4715



**"McKellin, Maren"** <mckellin@cod.edu>

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**Check Request - Gallagher**

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**"McKellin, Maren"** <mckellin@cod.edu>

Tue, Sep 10, 2024 at 01:39 PM UTC

CC: Kerby, Susan <kerbys@cod.edu>

BCC:

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Please pay the attached.

Thanks,

Maren

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**1 attachment**

2024 2025 invoice 1.pdf