

**Information:**

**Drawer:** Accounts Payable - Invoices

**Vendor Number:** 1082122

**Vendor Name:** Arthur J Gallagher Risk Management Services

**Check Details:**

**Check Number:** 0340398

**Check Amount:** \$ 5,022.01

**Check Date:** 6/24/2025

**Invoice Details:**

**Invoice Number:** 5636060,5634560

**Invoice Date:** 6/11/2025

**PO Number:** NULL

**Voucher Number:** V0891205

**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
Total			\$

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:

SEQY01

Invoice #	5636060	1 of 1
ACCOUNT NUMBER	DATE	
COLLOFD-08	6/11/2025	
BALANCE DUE ON	AMOUNT DUE	
6/11/2025	\$1,770.79	

College of DuPage  
425 Fawell Boulevard  
Glen Ellyn, IL 60137



Student Accident	PolicyNumber:	GLMN1866043A	Company:	ACE American Insurance Company	Effective:	4/15/2025 to 4/15/2026
Item #	Trans Eff Date	Due Date	Trans	Description	Amount	
38958355	4/15/2025	6/11/2025	AUDT	Study Abroad	\$1,770.79	
Total Invoice Balance:					\$1,770.79	



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

SEQY01

College of DuPage  
425 Fawell Boulevard  
Glen Ellyn, IL 60137

Invoice #	5636060
ACCOUNT NUMBER	DATE
COLLOFD-08	6/11/2025
BALANCE DUE ON	AMOUNT DUE
6/11/2025	\$1,770.79
AMOUNT PAID	

Please send your remittance to:

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



PAY ONLINE AT: [gallagheraffinity.epaypolicy.com](http://gallagheraffinity.epaypolicy.com)

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

SEQY01

Invoice #	5634560	1 of 1
ACCOUNT NUMBER	DATE	
COLLOFD-08	6/10/2025	
BALANCE DUE ON	AMOUNT DUE	
6/10/2025	\$3,251.22	

College of DuPage  
425 Fawell Boulevard  
Glen Ellyn, IL 60137



Student Accident      PolicyNumber: GLMN1866043A      Company: ACE American Insurance Company      Effective: 4/15/2025 to 4/15/2026

Item #	Trans Eff Date	Due Date	Trans	Description	Amount
38936054	4/15/2025	6/10/2025	AUDT	Study Abroad	\$3,251.22

Total Invoice Balance: \$3,251.22



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

SEQY01

College of DuPage  
425 Fawell Boulevard  
Glen Ellyn, IL 60137

Invoice #	5634560
ACCOUNT NUMBER	DATE
COLLOFD-08	6/10/2025
BALANCE DUE ON	AMOUNT DUE
6/10/2025	\$3,251.22
AMOUNT PAID	

Please send your remittance to:

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



PAY ONLINE AT: [gallagheraffinity.epaypolicy.com](http://gallagheraffinity.epaypolicy.com)

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

---

**Check Request - Gallagher**

---

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

Wed, Jun 11, 2025 at 08:02 PM UTC

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

BCC:

---

Please pay the attached.

Thanks,

Maren

---

**1 attachment**

Gallagher June 2025.pdf