

PRODUCER

INSURANCE COMPANY NAME

CODE:

SUB CODE:

AGENCY
CUSTOMER ID:

| POLICY NUMBER(S) | EFFECTIVE DATE | EXPIRATION DATE | LINE OF BUSINESS |
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Please be advised that we wish to name _____ **PRODUCER**
 _____ **as our exclusive representative effective** _____ **DATE**
 _____ **CODE #**

for the lines of business shown above, currently in force or submitted by application.

This authorization replaces any other authorization that may have been previously completed for any other insurance representative for the stated lines of business.

- Please rescind the _____ day waiting period**
- There will be no rescission letter**

INSURED'S SIGNATURE_____
DATE_____
TITLE (IF APPLICABLE)_____
COMPANY NAME (IF APPLICABLE)