



CANCELLATION REQUEST / POLICY RELEASE

DATE (MM/DD/YY)

PRODUCER		PHONE (A/C, No, Ext):	COMPANY NAME AND ADDRESS		NAIC CODE:
CODE:	SUB CODE:		POLICY TYPE		
AGENCY CUSTOMER ID:		INSURED NAME AND ADDRESS			
		CANCELLED POLICY INFORMATION			
		POLICY NUMBER		EFFECTIVE DATE AND HOUR OF CANCELLATION	CANCELLATION DATE
					TIME
					AM PM
		POLICY TERM		EFFECTIVE DATE	EXPIRATION DATE

 CANCELLATION REQUEST (Policy attached)

 POLICY RELEASE (Complete Statement Section Below)

POLICY RELEASE STATEMENT

The undersigned agrees that:

The above referenced policy is lost, destroyed or being retained.

No claims of any type will be made against the Insurance Company, its agents or its representatives, under this policy for losses which occur after the date of cancellation shown above.

Any premium adjustment will be made in accordance with the terms and conditions of the policy.

WITNESS	DATE	SIGNATURE OF NAMED INSURED	DATE
WITNESS	DATE	SIGNATURE OF NAMED INSURED	DATE
<input type="checkbox"/> LIEN HOLDER	<input type="checkbox"/> MORTGAGEE	<input type="checkbox"/> LOSS PAYEE	
		AUTHORIZED SIGNATURE	TITLE
		AUTHORIZED SIGNATURE	TITLE
		AUTHORIZED SIGNATURE	DATE
		AUTHORIZED SIGNATURE	DATE

FOR AGENCY/COMPANY USE

REASON FOR CANCELLATION		METHOD OF CANCELLATION	
<input type="checkbox"/> NOT TAKEN	<input type="checkbox"/> OTHER (Identify)	<input type="checkbox"/> FLAT	FULL TERM PREMIUM \$
<input type="checkbox"/> REQUESTED BY INSURED REWRITTEN (Complete below)		<input type="checkbox"/> SHORT RATE	
COMPANY		<input type="checkbox"/> PRO RATA	UNEARNED FACTOR
POLICY NUMBER	EFFECTIVE DATE	<input type="checkbox"/> PREMIUM CALCULATION SUBJECT TO AUDIT	RETURN PREMIUM \$
REMARKS			

New York Only: If you do not keep your auto insurance in force during the entire registration period, your motor vehicle registration will be suspended. If your vehicle is still uninsured after 90 days, your driver's license will be suspended. To avoid these penalties, you must surrender your registration certificate and plates before your insurance expires. By law, we must report the termination of auto insurance coverage to the Department of Motor Vehicles.

NAME AND ADDRESS

REQUEST/RELEASE DISTRIBUTION

	<input type="checkbox"/> INSURED	<input type="checkbox"/> LOSS PAYEE
	<input type="checkbox"/> MORTGAGEE	<input type="checkbox"/> LIEN HOLDER
	<input type="checkbox"/> COMPANY	<input type="checkbox"/> FINANCE COMPANY
PRODUCER'S SIGNATURE		DATE