Professional SOLUTIONS | INSURANCE COMPANY

Delegation of Certain Policy Rights REMOVAL

A. GENERAL INFORMATION

Name of Insured: ____
First Name | Middle | Last Name

Policy Number: ____

Mailing Address: ____
Street

____
City | State | ZIP

Office Phone: (__________)__________________ Fax: (__________)__________________

Home/Cell Phone: (__________)__________________ Email Address: __________________
Your email address will never be sold. It will be used to send you important messages.

B. EMPLOYER INFORMATION

Employer Name: ____

Employer Contact Person: ____
First Name | Middle | Last Name

Mailing Address: ____
Street

____
City | State | ZIP

C. STATUS CHANGE INFORMATION

❑ Please refund any unearned premium and remove the delegation of rights endorsement from this policy effective ______________________.

❑ Please cancel this policy effective __________________ and refund any unearned premium.

D. SIGNATURE REQUIRED

By signing below I authorize the above referenced changes. Notice of Cancellation and any applicable offer for extended reporting coverage will be mailed to the address of the insured as listed on this form. If no address is listed on this form, Notice of Cancellation and any applicable offer for extended reporting coverage will be mailed to the last known address of the insured.

______________________________ ______________________________
Employer Signature | Date

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Questions:
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