

# ACORD™ 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:		CANCELLED POLICY INFORMATION	
INSURED NAME AND ADDRESS		POLICY NUMBER	
		EFFECTIVE DATE AND HOUR OF CANCELLATION	CANCELLATION DATE
		TIME	
		POLICY TERM	EXPIRATION DATE

<b>CANCELLATION REQUEST (Policy attached)</b>	<b>POLICY RELEASE (Complete Statement Section Below)</b>
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### 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
			DATE
AUTHORIZED SIGNATURE			TITLE
			DATE

### FOR AGENCY/COMPANY USE

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

<b>NAME AND ADDRESS</b>	<b>REQUEST/RELEASE DISTRIBUTION</b>	
	<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
	<input type="checkbox"/>	<input type="checkbox"/>
PRODUCER'S SIGNATURE		DATE