



Crop Insurance Division

MULTIPLE PERIL CROP INSURANCE POLICY CHANGE AND CANCELLATION FORM

Policy Number _____

Page 1 of 2

Part I: INSURED'S INFORMATION

Name	Person Type
Authorized Representative	Identification Number
Street or Mailing Address	Identification Number Type (Check One) <input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN
City State Zip Code	Telephone Number

Part II: AGENT/AGENCY INFORMATION

Name	Code Number	Telephone Number
Street or Mailing Address	City State Zip Code	

Part III: SBI INFORMATION (List all persons with a substantial beneficial interest in you as defined in the applicable policy provisions (include landlords or tenants insured under the applicant). If none, state NONE.

Name	Address	Telephone Number	ID Number	ID No. Type (Check One)	Person Type
				<input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN	
				<input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN	
				<input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN	

☐ "Add authority for designated person(s) to sign crop insurance documents on behalf of the insured." ☐ By checking this box, I am authorizing all individuals listed as an SBI to also have authority as stated in the sentence below.

"I grant the person(s) listed below the authority to sign any and all crop insurance documents on my behalf. I understand that by authorizing such persons to sign documents on my behalf I am legally bound by all terms and conditions of such documents and of the crop insurance contract. I also understand that granting the following person(s) the authority to sign on my behalf does not obligate that person(s) to the terms and conditions of my crop insurance contract.

I further understand that this authorization may be revoked by me at any time upon written notice, signed and delivered to my Approved Insurance Provider."

_____ ☐ "Remove authority for designated person(s) to sign crop insurance documents on behalf of the insured."

Print Authorized Representative Name(s)

Added County Election ☐ Yes ☐ No I request insurance coverage for my share of the Category B crops (except forage production) specified below with a designated county in all added counties where the crops are insurable. If your designated plan of insurance, level of coverage or price is not available in the added county, coverage will be provided through the Catastrophic Risk Protection Endorsement, if the crop is insurable in the actuarial documents for an added county.

Part IV: CHANGE INSURANCE *(A plan of insurance cannot be changed using a Policy Change Form)

Effective Crop Year	State	County	Des. County	Name of Crop	Type, Class, Etc.	Plan of Insurance *(for ID purposes only)	% of Price Election, Projected Price, or Amount of Insurance	Coverage Level	Options, Elections, or Endorsements (check box and list option)
			<input type="checkbox"/>						<input type="checkbox"/> Add <input type="checkbox"/> Exclude <input type="checkbox"/> Cancel
			<input type="checkbox"/>						<input type="checkbox"/> Add <input type="checkbox"/> Exclude <input type="checkbox"/> Cancel



Crop Insurance Division

MULTIPLE PERIL CROP INSURANCE POLICY CHANGE AND CANCELLATION FORM

Policy Number _____

Page 2 of 2

I hereby request cancellation of my crop insurance policy for the crop(s) and crop year shown on this cancellation. I understand that if this form is not executed on or before the cancellation date for any crop year listed, the cancellation of insurance on such crop(s) will not become effective until the following crop year.

Part V: CANCEL INSURANCE

Effective Crop Year	State	County	Des. County	Name of Crop	Type, Class, Etc.	Plan of Insurance	% of Price Election, Projected Price, or Amount of Insurance	Coverage Level	Options, Elections, or Endorsements (check box and list option)
			<input type="checkbox"/>						<input type="checkbox"/> Add <input type="checkbox"/> Exclude <input type="checkbox"/> Cancel
			<input type="checkbox"/>						<input type="checkbox"/> Add <input type="checkbox"/> Exclude <input type="checkbox"/> Cancel

Part VI: REASONS FOR CANCELLATIONS (Check one and explain in remarks)

- ☐ Insured's Request ☐ Death, Incompetency, or Dissolution
☐ Mutual Consent ☐ Other

Remarks

Part VII: OTHER CHANGES (Check all that apply)

- ☐ Successor-In-Interest and Effective Crop Year _____ (of the successor in-interest transaction)
☐ Add/change/correct insured's authorized representative ☐ Change/correct insured's address
☐ Correct insured's identification number ☐ Correct spelling of insured's name
☐ Correct SBI's identification number ☐ Correct spelling of SBI's name
☐ Add or remove SBI

Part VIII: REQUIRED STATEMENTS

COLLECTION OF INFORMATION AND DATA (PRIVACY ACT) STATEMENT Agents, Loss Adjusters and Policyholders

The following statements are made in accordance with the Privacy Act of 1974 (5 U.S.C. 552a): The Risk Management Agency (RMA) is authorized by the Federal Crop Insurance Act (7 U.S.C. 1501-1524) or other Acts, and the regulations promulgated thereunder, to solicit the information requested on documents established by RMA or by approved insurance providers (AIPs) that have been approved by the Federal Crop Insurance Corporation (FCIC) to deliver Federal crop insurance. The information is necessary for AIPs and RMA to operate the Federal crop insurance program, determine program eligibility, conduct statistical analysis, and ensure program integrity. Information provided herein may be furnished to other Federal, State, or local agencies, as required or permitted by law, law enforcement agencies, courts or adjudicative bodies, foreign agencies, magistrate, administrative tribunal, AIPs contractors and cooperators, Comprehensive Information Management System (CIMS), congressional offices, or entities under contract with RMA. For insurance agents, certain information may also be disclosed to the public to assist interested individuals in locating agents in a particular area. Disclosure of the information requested is voluntary. However, failure to correctly report the requested information may result in the rejection of this document by the AIP or RMA in accordance with the Standard Reinsurance Agreement between the AIP and FCIC, Federal regulations, or RMA-approved procedures and the denial of program eligibility or benefits derived therefrom. Also, failure to provide true and correct information may result in civil suit or criminal prosecution and the assessment of penalties or pursuit of other remedies.

NONDISCRIMINATION STATEMENT

The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, age, disability and where applicable, sex, marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, reprisal, or because all or a part of an individual's income is derived from any public assistance program. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotope, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD).

To file a complaint of discrimination write to: USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6382 (TDD). USDA is an equal opportunity provider and employer.

Part IX: CERTIFICATION STATEMENT

"I certify that to the best of my knowledge and belief all of the information on this form is correct. I also understand that failure to report completely and accurately may result in sanctions under my policy, including but not limited to voidance of the policy, and in criminal or civil penalties (18 U.S.C. §1006 and §1014; U.S.C. §1506; U.S.C. §3729, §3730 and any other applicable federal statutes).

Insured's Printed Name

Signature

Date

Agent's Printed Name

Signature

Date

Code Number