

ACORD™ CANCELLATION REQUEST / POLICY RELEASE				DATE (MM/DD/YY)
PRODUCER	PHONE (A/C, No. Ext):	COMPANY NAME AND ADDRESS		NAIC CODE:
CODE: AGENCY CUSTOMER ID:	SUB CODE:	POLICY TYPE		
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.

*Amber Blaiss*  
WITNESS

DATE

SIGNATURE OF NAMED INSURED

DATE

*5/26/15*

*Michael Bishop*

*5/26/15*

WITNESS

DATE

SIGNATURE OF NAMED INSURED

DATE

LIEN HOLDER

MORTGAGEE

LOSS PAYEE

AUTHORIZED SIGNATURE

TITLE

DATE

LIEN HOLDER

MORTGAGEE

LOSS PAYEE

AUTHORIZED SIGNATURE

TITLE

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	<input type="checkbox"/> FULL TERM PREMIUM \$
REQUESTED BY INSURED REWRITTEN (Complete below)		<input type="checkbox"/> SHORT RATE	<input type="checkbox"/> UNEARNED FACTOR
COMPANY		<input type="checkbox"/> PRO RATA	<input type="checkbox"/> RETURN PREMIUM \$
POLICY NUMBER	EFFECTIVE DATE	PREMIUM CALCULATION SUBJECT TO AUDIT	
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	