

CROP INSURANCE APPLICATION/CANCELLATION - TRANSFER

APPLICANT'S NAME:			AGENCY:			AGENCY CODE:			POLICY NUMBER:			INSURED STATE:			
STREET AND/OR MAILING ADDRESS:					ADDRESS:					ISSUING COMPANY:					
CITY, STATE, ZIP CODE:					CITY, STATE, ZIP CODE:					<input type="checkbox"/> NEW <input type="checkbox"/> REINSTATE <input type="checkbox"/> TRANSFER <input type="checkbox"/> ADD CROP TO POLICY					
APPLICANT'S TELEPHONE NUMBER:					PHONE:			FAX:			PERSON TYPE (check one): <input type="checkbox"/> A - Public Schools <input type="checkbox"/> J - Joint operations/ventures and co-ownerships <input type="checkbox"/> B - Bureau of Indian Affairs and Indian Tribe Treaties <input type="checkbox"/> P - Partnership <input type="checkbox"/> C - Corporation <input type="checkbox"/> R - Trust - Revocable <input type="checkbox"/> D - Estates <input type="checkbox"/> S - Spousal/Married <input type="checkbox"/> E - Non-Profit or Tax-Exempt Organizations <input type="checkbox"/> T - Trust - Irrevocable <input type="checkbox"/> F - Transfer of Right to Indemnity (SBI only) <input type="checkbox"/> X - Individual Operating as a Business <input type="checkbox"/> G - Receiver or Liquidator <input type="checkbox"/> Y - Limited Liability Company <input type="checkbox"/> H - State/Local Government <input type="checkbox"/> I - Individuals				
POWER OF ATTORNEY (POA must accompany application):					APPLICANT 18 YEARS OR OLDER (circle one): YES NO			I AM A LIMITED RESOURCE FARMER (circle one): YES NO							
IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER TYPE: <input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> OTHER		NAME AND IDENTIFICATION NUMBER OF SPOUSE:			APPLICANT'S E-MAIL ADDRESS:								
Is applicant insuring the tenant's share? <input type="checkbox"/> Yes <input type="checkbox"/> No		List all person(s) with a companion policy and their policy numbers:													
Is applicant insuring the landlord's share? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Articles of Organization/Articles of Incorporation (circle one) and Location of Documents:															
List all person(s) with a substantial beneficial interest in you as defined in the applicable policy provisions (include landlords or tenants insured under the applicant with an 'L' Person Type). If none, state none. Required information: Name, Address, Telephone Number, Identification Number and Type, Person Type													ADDED COUNTY (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name		Complete Address			Phone Number		ID Number		ID Type		Person Type		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. [†] *Identify primary county/crops with S or N (statewide or nationwide) in the Insured County column. **Intended acres will not establish liability. An acreage report must be filed.		

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

CONDITIONS OF ACCEPTANCE: This application is accepted and insurance attaches in accordance with the policy unless: (1) The Federal Crop Insurance Corporation determines that, in accordance with the regulations, the risk is excessive; (2) any material fact is omitted, concealed or misrepresented in this application or in the submission of this application; (3) you have failed to provide complete and accurate information required by this application; or (4) the answer to any of the following questions is "yes." An answer of "yes" to these questions does not automatically result in rejection of the application. For example, if you answer "yes" to question (a) but your debt was discharged in bankruptcy; the application would not be rejected.

- YES NO (a) Are you now indebted and the debt is delinquent for insurance coverage under the Federal Crop Insurance Act?
- YES NO (b) Have you in the last five years been convicted under federal or state law of planting, cultivating, growing, producing, harvesting, or storing a controlled substance?
- YES NO (c) Have you ever had insurance coverage under the authority of the Federal Crop Insurance Act terminated for violation of the terms of the contract or regulations, or for failure to pay your delinquent debt?
- YES NO (d) Are you disqualified or debarred under the Federal Crop Insurance Act, the regulations of the Federal Crop Insurance Corporation, or the United States Department of Agriculture?
- YES NO (e) Have you ever entered into an agreement with the Federal Crop Insurance Corporation or with the Department of Justice that you would refrain from participating in programs under the authority of the Federal Crop Insurance Act and that agreement is still effective?
- YES NO (f) Do you have like insurance on any of the above crop(s)?

I understand that if coverage for any crop is currently terminated or would have subsequently terminated for indebtedness had this application been filed after the termination date, no coverage can be provided and I am ineligible for any benefits under the Federal Crop Insurance Act until the cause for termination is corrected.

We will notify you of rejection by depositing notification in the United States mail, postage paid, to the applicant's address. Unless rejected or the sales closing date has passed at the time you signed this application, insurance shall be in effect for the crop(s) and crop years specified and shall continue for each succeeding crop year, unless otherwise specified in the policy, until canceled, terminated or voided. No term or condition of the contract shall be waived or changed unless such waiver or change is expressly allowed by the contract and in writing.

APPLICANT MUST PROVIDE SIGNATURE ON FOLLOWING PAGE TO CERTIFY TO THE ACCURACY OF THE INFORMATION PROVIDED ABOVE AND OFFICIALLY APPLY FOR INSURANCE COVERAGE.

SUPPLEMENT COVERAGE OPTION ENDORSEMENT TERMS AND CONDITIONS: In addition to Section3B (2) of the Basic Provisions, I hereby elect this Supplemental Coverage Option Endorsement, and by this election I understand:

1. I must have purchased a policy under the Common Crop Insurance Policy Basic Provisions and applicable Crop Provisions to elect this Endorsement and must also purchase this Endorsement with the same Approved Insurance Provider as my Common Crop Insurance Policy.
2. I may elect coverage under this Endorsement and the Farm Service Agency's Agriculture Risk Coverage Program, but the same acreage of the crop cannot be covered under both programs.
3. I may elect coverage under this Endorsement and Stacked Income Protection Plan for the upland cotton, but the same acreage cannot be insured under both.
4. If at any time my Common Crop Insurance Policy for the crop is cancelled or terminated, coverage under this endorsement is automatically cancelled or terminated.
5. That by electing this Endorsement, it will continue from year to year unless I or you cancel or change my election by written notice on or before the cancellation date or my coverage is otherwise canceled or terminated under the terms of my policy.
6. Separate Administrative Fees will be assessed for each crop insured under this Endorsement.

Please indicate your election of the SCO Endorsement in the options column, by crop, on page 1 of this application.

Has applicant elected Agriculture Risk Coverage (ARC) with the FSA Office? (circle one) Yes No

CANCELLATION/TRANSFER of Experience Information - To be completed if canceling previous policy with another insurance provider.

PART I: I hereby request cancellation of my crop insurance policy(s) with _____ for the crop(s) and crop year(s) shown on this application for the following policy(s) _____ because I have applied for insurance with another Approved Insurance Provider. I understand that if this form is not executed on or before the established cancellation date for any crop listed, the cancellation of insurance on such crop(s) will not become effective until the following crop year. I hereby authorize and direct the ceding Approved Insurance Provider shown above to furnish any information relative to my insurance policy to the Assuming Approved Insurance Provider listed. I understand that if coverage for any crop(s) is now terminated or would have subsequently terminated for delinquent debt had this transfer not occurred, no coverage can be provided by the assuming Approved Insurance Provider.

PART II: By submission of this form, we agree to provide crop insurance to this applicant for the crop(s) and crop year specified above unless this form is not executed on or before the established cancellation date for any of the crop(s) shown, in which case insurance will be provided for such crop(s) for the following crop year.

CANCELLATION STATEMENT:

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.

SIGNATURE AUTHORITY STATEMENT: 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.

AUTHORIZED PERSON	AUTHORIZED PERSON	AUTHORIZED PERSON
AUTHORIZED PERSON	AUTHORIZED PERSON	AUTHORIZED PERSON

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 avoidance of the policy, and in criminal or civil penalties (18 U.S.C. §1006 and §1014; 7 U.S.C. §1506; 31 U.S.C. §3729, §3730 and any other applicable federal statutes).

I certify, for the crop year indicated, that I have not directly or indirectly received, accepted, or been paid, offered, promised, or given any benefit, including money, goods, or services for which payment is usually made, rebate, discount, abatement, credit, or reduction of premium, or any other valuable consideration, as an inducement to procure insurance or in exchange for purchasing this insurance policy after it has been procured. I understand that this prohibition does not include payment of administrative fees, performance based discounts, and any other payment approved by FCIC that are authorized under sections 508(a)(9)(B) and 508(d)(3) of the Federal Crop Insurance Act (Act) (7 U.S.C. §§ 1508(a)(9)(B) and 1508(d)(3)). I understand that a false certification or failure to completely and accurately report any information on this form may subject me, and any person with a substantial beneficial interest in me, to sanctions, including but not limited to, criminal and civil penalties and administrative sanctions in accordance with section 515(h) of the Act (7 U.S.C. §1515(h)) and all other applicable federal statutes.

 APPLICANT'S SIGNATURE

 DATE

 APPLICANT'S PRINTED NAME

I certify, for the crop year indicated, that I have neither offered nor promised, directly or indirectly, any benefit, including money, goods, or services for which payment is usually made, rebate, discount, credit, reduction of premium, or any other valuable consideration to this person either as an inducement to procure insurance or in exchange for obtaining insurance after it has been procured. I understand that this prohibition does not include payment of administrative fees, performance based discounts, and any other payment approved by FCIC that are authorized under sections 508(a)(9)(B) and 508(d)(3) of the Federal Crop Insurance Act (Act) (7 U.S.C. §§ 1508(a)(9)(B) and 1508(d)(3)). I understand that a false certification or failure to completely and accurately report any violation may subject me, and all agencies/companies I represent, to sanctions, including but not limited, to criminal and civil penalties and administrative sanctions in accordance with section 515(h) of the Act (7 USC §1515(h)) and all other applicable federal statutes.

 AGENT'S SIGNATURE

 DATE

 AGENT'S CODE NUMBER AND PRINTED NAME

 INSURANCE PROVIDER

 DATE

Non Discrimination Statement

The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

To File a Program Complaint:

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at <https://www.ascr.usda.gov/ad-3027-usda-program-discrimination-complaint-form>, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter by mail to the U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Persons with Disabilities:

Individuals who are deaf, hard of hearing or have speech disabilities and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish). Persons with disabilities, who wish to file a program complaint, please see information above on how to contact the Department by mail directly or by email. If you require alternative means of communication for program information (e.g., Braille, large print, audiotape, etc.) please contact USDA's TARGET Center at (202) 720-2600 (voice and TDD).

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.