MPCI F.18168F (09/17)

GREAT AMERICAN INSURANCE COMPANY | Crop Insurance

Multiple Peril Crop Insurance Assignment Of Indemnity

Effective Crop Year _____

Policy Number _____

Part I: INSURED'S INFORMATION			**Part II: AGENT/AGENCY INFORMATION**		
Name			Name		
Authorized Representative			Code Number	Telephone Number	
Street or Mailing Address			Street or Mailing Address		
City	State	Zip Code	City	State	Zip Code

Part III TERMS AND CONDITIONS

The Insured assigns to _____ of _____ of _____

(Name of Creditor) (Street or Mailing Address) (City State Zip Code)

_____

(Phone Number)

the right and interest of any indemnity payment(s) which may be payable to the insured under the insurance policy for the county/commodity(ies) shown:

Crop Name	**County Name**	**Crop Name**	**County Name**

CONDITIONS

(1) This assignment will be binding upon the person(s) who succeed the insured's interest in the insurance policy,

(2) Indemnity payments made under the insurance policy will be subject to a deduction for any indebtedness due this Approved Insurance Provider by the insured,

(3) This assignment will not grant the Creditor any greater rights than originally held by the insured.

(4) The Creditor's interest will be recognized upon Approved Insurance Provider's approval of this assignment and the Creditor will have the right to submit the loss notices and other forms as required by the insurance policy,

(5) The Approved Insurance Provider will determine the person(s) entitled to any indemnity payment(s) and the payment(s) will be by joint check,

(6) Cancellation of this assignment prior to and during the crop year stated above will be accepted by the Approved Insurance Provider only upon notification in writing by the above identified Creditor(s). It is understood and agreed that this assignment will be subject to the terms and conditions of the insurance policy."

(7) "If the assignment is not canceled according to item (6), the assignment will cease at the end of the effective crop year.

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Part IV: 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

Non-Discrimination Policy - 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).

Insured's Printed Name	Signature	Date	Creditor's Printed Name	Signature	Date
Witness' Printed Name	Signature	Date	Witness' Printed Name	Signature	Date

Part V: APPROVED INSURANCE PROVIDER AUTHORIZATION

This assignment was filed with the approved insurance provider on _____ , _____ at _____ ❑ AM ❑ PM.
(Month & Day) (Year) (Time) (Check One)

The approved insurance provider hereby approves the foregoing assignment _____ Date_____
(Approved Insurance Providers Authorized Representative Printed Name and Signature)