RCIS®
RURAL COMMUNITY INSURANCE COMPANY

Power of Attorney

The undersigned does hereby make, constitute and appoint ______________________ of
1. Name

______________________ in the County of ______________________
2. Residing in City **3. Residing in County**

and State of ______________________ the true and lawful attorney, for and in the name, place and stead of the undersigned in
4. Residing in State

connection with Insurance Policy and/or ______________________ insured with Rural Community Insurance Services.
5. Policy

The undersigned gives and grants unto said attorney full authority and power to do and perform actions as initialed below fully ratifying and confirming all that said attorney 'shall lawfully do or cause to be done by virtue hereof: (This power of attorney is not affected by subsequent disability or incapacity of the principal.)

- ☐ 1. Giving notice of damage or loss.
- ☐ 2. Making application for insurance.
- ☐ 3. Making claim for indemnity.
- ☐ 4. Making policy changes.
- ☐ 5. Making crop acreage reports.
- ☐ 6. Making transfers and cancellations
- ☐ 7. Taking all actions related to the insurance coverage provided under the above identified policy and/or policy number.
- ☐ 8. Providing program required production records.

This Power of Attorney shall be filed at the office where the official insurance file folder is maintained and shall remain in full force and effect until written notice of its revocation has been received by the office maintaining the official insurance file folder (such revocation shall be placed in the official insurance file folder).

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, AIP's 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).

This Power of Attorney is signed and dated at ______________________ , ______________________ this
6. Signed in City **7. Signed in State**

______________________ day of ______________________ , ______________________ .
8. Signed on Day **9. Signed on Month** **10. Signed on Year**

______________________ ______________________
11. Insured's Printed Name **12. Insured's Signature**

______________________ ______________________
13. Witness' Printed Name **14. Witness' Signature**

______________________ ______________________
15. Witness' Printed Name **16. Witness' Signature**

I hereby accept the foregoing appointment

______________________ ______________________
17. Appointee's Printed Name **18. Appointee's Signature**

Acknowledgement
(For use by Notary Public)
(Use acknowledgement form if required by the State where acknowledgement is taken.)
Signatures of the insured and the appointee must be notarized when required by law.
Witness signatures are not required if notarized.

State of: ______________________

County of: ______________________

Signature of Notary: ______________________

Notary Seal

Please do not write over this section.