CAPITOL

PAYMENT PLAN

Fax to: 518-862-7520
Att: Jill Evanchuk

Authorization to Change Broker/Agent of Record

Insurance Company: _____ Insured's Name: _____

Ins. Co. Address: _____ Policy Number: _____

_____

Statement of Insured:

I, _____, hereby request my insurance company named above to recognize my new Broker/Agent of record:

New Broker Name: _____

Effective date as of _____ (must not be earlier than postmark date)

Insured's Signature: _____ Date: _____

New Broker/Agent Information:

Broker/Agent Name: _____

Address: _____

_____

Phone: _____ Email: _____

Statement of New Broker Agent:

I hereby certify that I am a duly licensed producer in the State of New York.

New Broker/Agent Signature: _____Date:_____