Professional SOLUTIONS | INSURANCE COMPANY

Delegation of Certain Policy Rights

By signing this form I delegate to my employer:

1. The right to cancel my policy and;
2. The right to receive any unearned premium refund due to such cancellation or due to policy changes for which my employer has paid the premium.

I request that copies of all correspondence and formal notice regarding the policy be sent to me at my last mailing address of record.

Note: This authorization is continuous until PSIC receives one of the following: (1) written notice from the employer to cancel the policy; (2) written notice from the employer releasing this authorization; or, (3) written notice that the employment agreement has been terminated.

A. INSURED INFORMATION

Insured's Name: _____
First Name Middle Last Name

Policy Number: _____

Insured's Signature: _____

Date Signed: _____

Effective Date: _____

B. EMPLOYER INFORMATION

Employer Name: _____

Employer Mailing Address: _____
Street

_____
City State ZIP

Employer Signature: _____ Date: _____

Consent: Eng Dak _____
PSIC Insurance Company

Date Received by PSIC: _____

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