

CAPITOL

PAYMENT PLAN

Authorization to Change Broker/Agent of Record

Insurance Company: _____ Insured's Name: _____

Company Address: _____ Policy Number: _____

Statement of Insured:

_____, hereby request my insurance company named
above to recognize my new Broker/Agent of record _____
(New Broker/Agent)
effective as of _____.
(must not be earlier than postmark date)

Insured's Signature: _____ Date: _____

New Broker/Agent Information:

Broker/Agent Name: _____

Address: _____

Phone: _____

Email Address: _____

(Please note if case sensitive & also when to use alpha or numeric)

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: _____

This form must be fully completed, signed by both the insured and the Broker/Agent and forwarded immediately to CAPITOL PAYMENT PLAN.

Insurance Premium Financing