



NCMIC

Insurance Company

Delegation of Certain Policy Rights

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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; and,
- (3) the right to receive any dividend attributable to any policy period for which my employer has paid the premium.

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

Note: This authorization is continuous until NCMIC 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.

_____ (Insured's Name)
 _____ (Policy Number)
 _____ (Insured's signature)
 _____ (Date Signed)
 _____ (Effective Date)

Employer Name: _____

Employer Mailing Address: _____

Employer Signature: _____

Consent:  _____
NCMIC Insurance Company

Date Received by NCMIC: _____

NCMIC will issue an endorsement to be attached to your policy as confirmation your request has been recorded at our Home Office

RETURN THIS FORM

Mail this form to:
NCMIC Insurance Company
P.O. Box 9118
Des Moines, IA 50306

Or fax it to:
1-800-996-2642

Questions? Call toll free
1-800-247-8043