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 BY MAIL, FAX OR EMAIL

Mail:	Fax:	Email:	Questions? Call toll free
NCMIC Insurance Company P.O. Box 9118 Des Moines, IA 50306	**1-800-996-2642**	**submissions@ncmic.com**	**1-800-247-8043**