

IDAHO DEPARTMENT OF INSURANCE TERMINATION

OF AUTHORITY TO ACT UNDER **COMPANY OR AGENCY/FIRM** LICENSE

Date: _____

Termination for: Individual Agency

Name of Producer: _____

Idaho License Number: _____

Line(s) of Authority to be Terminated:

- | | | | |
|---------------------------------|--|---|-----------------------------------|
| <input type="checkbox"/> Life | <input type="checkbox"/> Disability (Health) | <input type="checkbox"/> Casualty | <input type="checkbox"/> Property |
| <input type="checkbox"/> Surety | <input type="checkbox"/> Variable | <input type="checkbox"/> Personal Lines | <input type="checkbox"/> Credit |
| <input type="checkbox"/> Travel | <input type="checkbox"/> Other: _____ | | |

Notice is hereby given that the above listed individual/agency is shall no longer be authorized to act under our company/agency/firm license for the lines of authority indicated above.

Effective Date: _____ (*cannot be backdated more than 30 days)

Agency Name: _____

NAIC# or Idaho License #: _____ FEIN #: _____

Signature of Authorized Individual (See #1 below)

Printed Name/Title

NOTE:

1. This request must be signed by an authorized individual of the firm or company unless a producer is terminating an appointment or registration, in which case the producer may sign, but is responsible for notifying any insurers or agencies that may be affected by this transaction.
2. Please fax completed form to 208-334-4398 or email to agent@doi.idaho.gov.
3. If termination is for cause, please attach explanation and supporting documentation.
4. *Terminations cannot be backdated more than 30 from date Idaho Dept. of Insurance receives the request.
5. For confirmation of this transaction, please consult our website to view your agency record at www.doi.idaho.gov. Allow a minimum of 24 hours for processing.

In case we have questions, please provide a contact name, email, and phone below:

Contact name _____ Phone: _____

Email address: _____