



ARKANSAS INSURANCE DEPARTMENT
LICENSE DIVISION
1200 WEST 3RD STREET
LITTLE ROCK, AR 72201
PHONE: 501-371-2750
FAX: 501-683-2604

ADDRESS CHANGE FORM

INSTRUCTIONS: All areas of this form that relate to the individual or the agency must be completed. If information does not apply, then mark the section N/A. WE MUST HAVE A PHYSICAL ADDRESS FOR THE RESIDENCE. WE MUST HAVE A CURRENT E-MAIL ADDRESS. Use a separate form for each individual and for each agency -- do not combine an individual and an agency on the same form -- combinations will not be processed. This form must be printed in ink, typed or computer generated. The form must be legible or the change will not be made. There is no charge for a change of address and this form may be computer generated or duplicated. COMPLETED FORM MAY BE MAILED OR FAXED TO 501-683-2604. This form cannot be used for a name change for an individual or a business entity.

INDIVIDUAL:

Name \_\_\_\_\_

Social Security or License Number: \_\_\_\_\_

Current Mailing Address: \_\_\_\_\_

P.O. Box or Street Number City State Zip

Current Residence Address: \_\_\_\_\_

Street Number City State Zip
(Must be a physical address, cannot use P.O. Box. In a small town, General Delivery is acceptable.)

Current Business Address: \_\_\_\_\_

Street Number City State Zip
(Must have a physical address, you can also include P.O. Box.)

Current Home Phone: \_\_\_\_\_ Current Business Phone: \_\_\_\_\_

Current Fax: \_\_\_\_\_ Current E-Mail Address: \_\_\_\_\_

Please change the information on my record to reflect this current information. I understand if I change my state of residence, additional requirements will apply.

Signature of Licensee \_\_\_\_\_ Dated: \_\_\_\_\_

BUSINESS ENTITY (AGENCY):

Name \_\_\_\_\_

FEIN Number: \_\_\_\_\_

Current Mailing Address: \_\_\_\_\_

P.O. Box or Street Number City State Zip

Current Physical Address: \_\_\_\_\_

(Must be a physical address, cannot use P.O. Box) Street Number City State Zip

Agency Contact Person \_\_\_\_\_ Agency Phone: \_\_\_\_\_

Agency Fax: \_\_\_\_\_ E-mail of Contact Person: \_\_\_\_\_

Please change the information on the agency record to reflect this current information. I understand that an agency name change or move to another state of domicile requires additional information.

Signature of Agency Contact Person \_\_\_\_\_ Dated: \_\_\_\_\_