

ASSIGNMENT OF INDEMNITY

			Approved Insurance Provider's Name & Address:	
Insured's Name				
Insured's Authorized Representative				
Street or Mailing Address		Crop(s)	Policy Number	
City	State	Zip Code	County(ies)	Effective Crop Year
<p>The insured assigns to _____ (Name of Creditor)</p> <p>of _____ (Street and/or Mailing Address)</p> <p>_____ (City, State and Zip Code)</p> <p>the right and interest of any indemnity payment(s) which may be payable to the insured under the insurance policy for the county(ies)/commodity(ies) shown above.</p> <p style="text-align:center;">CONDITIONS</p> <ol style="list-style-type: none"> 1. This assignment will be binding upon the person(s) who succeeds the Insured's interest in the insurance policy. 2. Indemnity payments made under the insurance policy will be subject to a deduction for any indebtedness due this Approved Insurance Provider by the Insured. 3. This assignment will not grant the Creditor any greater rights than originally held by the Insured. 4. The Creditor's interest will be recognized upon Approved Insurance Provider's approval of this assignment and the Creditor will have the right to submit the loss notices and other forms as required by the insurance policy. 5. The Approved Insurance Provider will determine the person(s) entitled to any indemnity payment(s) and the payment(s) will be by joint check. 6. If the assignment is not cancelled according to item 7 below, the assignment will cease at the end of the effective crop year. 7. Cancellation of this assignment prior to and during the crop year stated above will be accepted by the Approved Insurance Provider only upon notification in writing by the above identified Creditor(s). <p>This assignment was filed with the Approved Insurance Provider on _____, _____ at _____ a.m./p.m. [MONTH] [DAY] [YEAR] [INSERT HOUR]</p>				

(See Reverse Side for Required Statements & Signature Blocks)

**COLLECTION OF INFORMATION AND DATA (PRIVACY ACT) STATEMENT
Agents, Loss Adjusters and Policyholders**

The following statements are made in accordance with the Privacy Act of 1974 (5 U.S.C. 552a): The Risk Management Agency (RMA) is authorized by the Federal Crop Insurance Act (7 U.S.C. 1501-1524) or other Acts, and the regulations promulgated thereunder, to solicit the information requested on documents established by RMA or by approved insurance providers (AIPs) that have been approved by the Federal Crop Insurance Corporation (FCIC) to deliver Federal crop insurance. The information is necessary for AIPs and RMA to operate the Federal crop insurance program, determine program eligibility, conduct statistical analysis, and ensure program integrity. Information provided herein may be furnished to other Federal, State, or local agencies, as required or permitted by law, law enforcement agencies, courts or adjudicative bodies, foreign agencies, magistrate, administrative tribunal, AIP's contractors and cooperators, Comprehensive Information Management System (CIMS), congressional offices, or entities under contract with RMA. For insurance agents, certain information may also be disclosed to the public to assist interested individuals in locating agents in a particular area. Disclosure of the information requested is voluntary. However, failure to correctly report the requested information may result in the rejection of this document by the AIP or RMA in accordance with the Standard Reinsurance Agreement between the AIP and FCIC, Federal regulations, or RMA-approved procedures and the denial of program eligibility or benefits derived therefrom. Also, failure to provide true and correct information may result in civil suit or criminal prosecution and the assessment of penalties or pursuit of other remedies.

NONDISCRIMINATION STATEMENT

In accordance with Federal law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating on the basis of race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs).

To File a Program Complaint

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at <https://www.ascr.usda.gov/ad-3027-usda-program-discrimination-complaint-form>, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter by mail to the U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or email at program.intake@usda.gov.

Persons with Disabilities

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotope, American Sign Language, etc.) should contact the responsible State or local Agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

Persons with disabilities, who wish to file a program complaint, please see information above on how to contact the Department by mail directly or by email.

It is understood and agreed that this assignment will be subject to the terms and conditions of the insurance policy.			
Insured's Printed Name		Creditor's Authorized Representative Printed Name	
Insured's Signature	Date	Creditor's Authorized Representative Signature	Date
Witness' Printed Name		Creditor's Authorized Representative's Telephone Number	
Witness' Signature		Witness' Printed Name	
Witness' Signature		Witness' Signature	
Witness' Date		Date	
AIP's Authorized Representative's Printed Name			
AIP's Authorized Representative's Signature		Date	