

Policy Transfer/Application
 With Supplemental Coverage Endorsement
 Multiple Peril Crop Insurance



Identification Number: (Tax ID)		Effective Crop Year:		Policy #:		
Type of Identification Number: <input type="radio"/> SSN <input type="radio"/> EIN <input type="radio"/> RAN		State:		Agency Code		
Person Type: Additional Documentation may be required*		County(ies)		Agency/Agent Name and Address:		
State in which articles of incorporation/organization are held:						
Applicant's Name:						
Applicant's Authorized Rep.:						
Street or Mailing Address:		In addition to my share on this policy, I am insuring: <input type="radio"/> My landlord's share <input type="radio"/> My tenant's share under my crop policy. I am providing a Power of Attorney or Lease Agreement as evidence of my authority to insure their share.				
City:	State:					Zip:
Telephone Number:						
Is applicant at least 18 years old? <input type="radio"/> Yes <input type="radio"/> No		Added County (select only one) <input type="radio"/> (National) I request insurance coverage for my share of the Category B crops (except forage production) specified below with a designated county in all added counties where the crops are insurable. <input type="radio"/> (State) I request insurance coverage for my share of the Category B crops (except forage production) specified below with a designated county in all added counties within the state where the crops are insurable.				
Name of Parent or Guardian:		Name of Previous AIP (if any)				
Spouse's Name:		Previous Policy Number under Previous AIP (if any)				
Spouse's Identification Number:						
Applicant's Additional Telephone Numbers:						
Applicant's Email Address:						

List all person(s) with a substantial beneficial interest in you as defined in the applicable policy provisions (include landlords or tenants insured under the applicant). If none, state NONE.

Name	ID Number & Type	Landlord/Tenant	Person Type	Address	Telephone
1)		<input type="radio"/> Yes <input type="radio"/> No			
2)		<input type="radio"/> Yes <input type="radio"/> No			
3)		<input type="radio"/> Yes <input type="radio"/> No			

Please Complete a **SOCIAL SECURITY NUMBER AND EMPLOYER IDENTIFICATION NUMBER REPORTING** form for additional substantial beneficial interest entities when applicable.

NEW PRODUCER A New Producer Verification Form is required to be submitted to NAU Country. An Intended Acreage form is a mandatory requirement for Prevented Planting that must be submitted & signed by the Sales Closing Date. Previous planted acres in the county negate Intended Acres reported on this form.

Yes No **Applicant has land that is affected by an FCI-33 Map which is part of the RMA County Actuarial Document for the applicable county (High Risk Land, Unrated Land, T-Yield Map Area, etc.)**

Effective Crop Year	County	Desig Cty	Code R, N, T	Name of Crop	Plan of Insurance	Additional Coverage	Practice, Type, Class, Etc.	Cov Level	% of Price Election Projected Price, Amount of Ins.	Options, Elections, or Endorsements	Intended Acres	EASYhail	
												Hail Plan	\$/Acre
						<input type="checkbox"/> SCO †							
						<input type="checkbox"/> SCO †							
						<input type="checkbox"/> SCO †							
						<input type="checkbox"/> SCO †							
						<input type="checkbox"/> SCO †							
						<input type="checkbox"/> SCO †							

Authority to sign crop insurance documents on behalf of the insured
 "I grant the person(s) listed below the authority to sign any and all crop insurance documents on my behalf. I understand that by authorizing such persons to sign documents on my behalf I am legally bound by all terms and conditions of such documents and of the crop insurance contract. I also understand that granting the following person(s) the authority to sign on my behalf does not obligate that person(s) to the terms and conditions of my crop insurance contract. I further understand that this authorization may be revoked by me at any time upon written notice, signed and delivered to my Approved Insurance Provider."

Name	Address	Telephone	Grant	Remove
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

This policy shall continue for each succeeding crop year until cancelled or terminated as provided in the policy.

† If selecting SCO, please complete page 2

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Insured's Name:	Agency Code:	Policy Number:
	Agency Name:	

Please complete ARC coverage question for lines with SCO values.

Effective Crop Year	County	Name of Crop	Underlying Plan Of Insurance	Type, Class, Etc.	Underlying Coverage Level	SCO Plan of Insurance	ARC Coverage
							<input type="radio"/> Yes <input type="radio"/> No
							<input type="radio"/> Yes <input type="radio"/> No
							<input type="radio"/> Yes <input type="radio"/> No
							<input type="radio"/> Yes <input type="radio"/> No
							<input type="radio"/> Yes <input type="radio"/> No
							<input type="radio"/> Yes <input type="radio"/> No

In addition to Section 3B(2) of the Basic Provisions, I hereby elect this Supplemental Coverage Option Endorsement, and by this election I understand:

(1) I must have purchased a policy under the Common Crop Insurance Policy Basic Provisions and applicable Crop Provisions to elect this Endorsement and must also purchase this Endorsement with the same Approved Insurance Provider as my Common Crop Insurance Policy

(2) I may elect coverage under this Endorsement and the Farm Service Agency's Agricultural Risk Coverage Program, but the same acreage of the crop cannot be covered under both programs.

(3) I may elect coverage under this Endorsement and Stacked Income Protection Plan for the upland cotton, but the same acreage cannot be insured under both.

(4) If at any time my Common Crop Insurance Policy for the crop is cancelled or terminated, coverage under this endorsement is automatically terminated, coverage under this endorsement is automatically cancelled or terminated.

(5) That by electing this Endorsement, it will continue from year to year unless I or you cancel or change my election by written notice on or before the cancellation date or my coverage is otherwise canceled or terminated under the terms of my policy.

(6) Separate Administrative Fees will be assessed for each policy insured under this Endorsement

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Insured's Name:	Agency Code:	Policy Number:
	Agency Name:	

CONDITIONS OF ACCEPTANCE: This application is accepted and insurance attaches in accordance with the policy unless: (1) The Federal Crop Insurance Corporation determines that, in accordance with the regulations, the risk is excessive; (2) any material fact is omitted, concealed or misrepresented in this application or in the submission of this application; (3) you have failed to provide complete and accurate information required by this application; or (4) the answer to any of the following questions is "yes." An answer of "yes" to these questions does not automatically result in rejection of the application. For example, if you answer "yes" to question (a) but your debt was discharged in bankruptcy; the application would not be rejected.

- | | | |
|-----------------------|-----------------------|--|
| Yes | No | |
| <input type="radio"/> | <input type="radio"/> | (a) Are you now indebted and the debt is delinquent for insurance coverage under the Federal Crop Insurance Act? |
| <input type="radio"/> | <input type="radio"/> | (b) Have you in the last five years been convicted under federal or state law of planting, cultivating, growing, producing, harvesting, or storing a controlled substance? |
| <input type="radio"/> | <input type="radio"/> | (c) Have you ever had insurance coverage under the authority of the Federal Crop Insurance Act terminated for violation of the terms of the contract or regulations, or for failure to pay your indebtedness? |
| <input type="radio"/> | <input type="radio"/> | (d) Are you disqualified or debarred under the Federal Crop Insurance Act, the regulations of the Federal Crop Insurance Corporation, or the United States Department of Agriculture? |
| <input type="radio"/> | <input type="radio"/> | (e) Have you ever entered into an agreement with the Federal Crop Insurance Corporation or with the Department of Justice that you would refrain from participating in programs under the authority of the Federal Crop Insurance Act and that agreement is still effective? |
| <input type="radio"/> | <input type="radio"/> | (f) Do you have like insurance on any of the above crop(s)? |

I understand that if coverage for any crop is currently terminated or would have subsequently terminated for indebtedness had this application been filed after the termination date, no coverage can be provided and I am ineligible for any benefits under the Federal Crop Insurance Act until the cause for termination is corrected.

We will notify you of rejection by depositing notification in the United States mail, postage paid, to the applicant's address. Unless rejected or the sales closing date has passed at the time you signed this application, insurance shall be in effect for the crop(s) and crop years specified and shall continue for each succeeding crop year, unless otherwise specified in the policy, until canceled, terminated or voided. The insurance contract, which includes the accepted application, is defined in the regulation published at 7 CFR chapter IV. No term or condition of the contract shall be waived or changed unless such waiver or change is expressly allowed by the contract and is in writing.

Crop Hail Underwriting Certification:

1. Have any of the listed crops received hail damage prior to signing the application? Yes No
2. Has additional insurance been purchased on the above crops? Yes No
3. Do you wish to exclude hail coverage on acres not insured under the MPCI policy? Yes No
(Uninsurable acres will be included unless otherwise indicated)

Part I: POLICY TRANSFER to NAU Country

I hereby request cancellation of my insurance policy with _____ for the crop(s) and crop year(s) shown above
(Ceding Approved Insurance Provider)

because I have applied for insurance with another Approved Insurance Provider. I understand that if this form is not executed on or before the established cancellation date for any crop listed, the cancellation of insurance on such crop(s) will not become effective until the following crop year. Policy number _____

I hereby authorize and direct the _____ shown above to furnish any information relative to my insurance
(Ceding Approved Insurance Provider)
 policy to the Assuming Approved Insurance Provider listed below. I understand that if coverage for any crop(s) is now terminated or would have subsequently terminated for delinquent debt had this transfer not occurred, no coverage can be provided by the NAU Country Insurance Company.
(Assuming Approved Insurance Provider)

Remarks:

Part II: POLICY TRANSFER to NAU Country Insurance Company

By submission of this form, we agree to provide crop insurance to this applicant for the crop(s) and crop year specified above unless this form is not executed on or before the established cancellation date for any of the crop(s) shown, in which case insurance will be provided for such crop(s) for the following crop year."

Signature of NAU Country Authorized Representative	RO CODE : NA	Date of Acceptance by Assuming Approved Insurance Provider
Signature:		

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Insured's Name:	Agency Code:	Policy Number:
	Agency Name:	

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

Non-Discrimination Policy

The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited basis will apply to all programs and/or employment activities.)

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 http://ascr.usda.gov/complaint_filing_cust.html, or 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, Director, Office of Adjudication, 1400 Independence Avenue, S.W. Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Persons with Disabilities

Individuals who are deaf, hard of hearing or have speech disabilities and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish).

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. If you require alternative means of communication for program information (e.g., Braille, large print, audiotope, etc.) please contact USDA's TARGET Center at (202) 720-2600 (voice and TDD).

CERTIFICATION STATEMENT

I certify that to the best of my knowledge and belief all of the information on this form is correct. I also understand that failure to report completely and accurately may result in sanctions under my policy, including but not limited to voidance of the policy, and in criminal or civil penalties (18 U.S.C. §1006 and §1014; 7 U.S.C §1506; 31 U.S.C. §3729, §3730 and any other applicable federal statutes).

Applicant's /Insured's Printed Name & Signature

Date

Printed Name:

Signature:

Name of Assuming Agent (Please Print)

Address of Assuming Agent

Date

Agent's Printed Name & Signature

Code Number

Date

Printed Name:

Signature: