MISSISSIPPI INSURANCE DEPARTMENT

P.O. BOX 79, JACKSON, MS 39205

MIKE CHANEY, Commissioner of Insurance

DEPARTMENT USE ONLY

APPOINTMENT CANCELLATION NOTIFICATION FORM

Company Name:_____ Company NAIC#:_____

Company Mailing Address: _____
_____
_____

Please cancel certificates of authority for the following producers/agents to transact business on behalf of the above company effective ___/____/_____.

	LICENSE NUMBER	SSN #	PRODUCER NAME LAST FIRST MIDDLE	REASON FOR TERMINATION
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

The insurer shall mail a copy of this notification to the producer at his or her last known address within fifteen (15) days.

If the reason for termination is one of the reasons set forth in Miss. Code Ann. § 83-17-71 or the insurer has knowledge the producer was found by a court government body or self-regulatory organization authorized by law to have engaged in any of the activities set forth in Miss. Code Ann. § 83-17-71, you shall provide any additional information, documents, records or other data pertaining to the termination or activity of the producer. If the producer is terminated for cause, for any of the reasons listed in Miss. Code Ann. § 83-17-71, the insurer shall provide notification to producer as set forth in Miss. Code Ann. § 83-17-77 (4).

_____ _____
Signature of Company Officer or Authorized Individual Printed Name & Title of Signatory

_____ _____/_____/_____
Telephone Number of Signatory Date

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