

**STATEWIDE INSURANCE CORP.  
CANCELLATION REQUEST / POLICY RELEASE FORM**

Producer Name: Address 1: Address 2: City, State, Zip: Phone: Email Address:	Policy Issuing Insurance Company
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Insured Name: Address 1: Address 2: City, State, Zip: Phone: Email Address:	Policy Number: <div style="background-color: #cccccc; height: 15px; width: 100%;"></div> Effective Date: Expiration Date: <div style="background-color: #cccccc; height: 15px; width: 100%;"></div> Cancellation Date:
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<b>CANCELLATION REQUEST (Policy Attached)</b>	<b>POLICY RELEASE (Complete Section Below)</b>
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**POLICY RELEASE STATEMENT**

The Undersigned agrees that:

The above referenced policy is lost, destroyed or being retained.  
 No claims of any type will be made against the Insurance Company, its agents or its representatives under this policy for losses which occur after the date of cancellation shown above.  
 Any premium adjustment will be made in accordance with the terms and conditions of the policy.

Witness	Date	Signature of Named Insured	Date
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Witness	Date	Signature of Named Insured	Date
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<b>REASON FOR CANCELLATION</b> <input type="checkbox"/> NOT TAKEN <input type="checkbox"/> REQUESTED BY INSURED <input type="checkbox"/> REWRITTEN <input type="checkbox"/> OTHER	Notes / Comments:
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PRODUCER'S SIGNATURE:	DATE:
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<b>FOR COMPANY USE ONLY</b>	
<b>METHOD of CANCELLATION</b>	
<input type="checkbox"/>	Pro Rate
<input type="checkbox"/>	Short Rate
<input type="checkbox"/>	Flat