



**ASSOCIATED MUTUAL
INSURANCE COOPERATIVE**
PO BOX 307
WOODRIDGE, NEW YORK 12789
845/434-4550 FAX 845/434-5430

IMPORTANT SPECIAL NOTICE TO SENIOR CITIZEN INSUREDS

If you are 65 years of age or older, are a New York State resident and are both the policyholder and the insured, you are entitled to appoint a third party to receive copies of any notice of cancellation, non-renewal or conditional renewal which may affect your insurance policy with this Company.

If you meet the above criteria and wish to take advantage of this service you may proceed as follows:

- 1) Provide this Company at the address noted above, with written notification of the third party designee by Certified Mail-Return Receipt Requested. You may use the bottom portion of this form for this purpose.
- 2) This notification must contain:
 - a) The name and policy number of the senior citizen insured.
 - b) The complete current name and mailing address of the third party designee.
 - c) Written and signed acceptance by the third party designee to receive this information.
- 3) Designation will take effect within ten(10) business days from our receipt of the notification.
- 4) If and when the third party designee wishes to terminate his/her status as such, they must provide written notice of their intent to both the Company and the senior citizen insured.

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I certify that I am a New York State resident; both the policyholder and the insured of the policy listed, and I am 65 years of age or older.

NAME: _____

MAILING ADDRESS: _____

POLICY#: _____ SIGNATURE: _____ DATE: _____

I hereby appoint _____ to be my Third Party Designee to receive copies on notices of cancellation, non-renewal or conditional renewal of the above policy.

DESIGNEE NAME: _____

MAILING ADDRESS: _____

SIGNATURE OF DESIGNEE: _____ DATE: _____

Should you, as designee, desire to terminate your status as a Third Party Designee you shall provide written notice of this termination to both Associated Mutual Insurance Cooperative and the Senior Citizen Insured.

TO BE EFFECTIVE, THIS NOTICE MUST BE RETURNED TO ASSOCIATED MUTUAL INSURANCE COOPERATIVE BY CERTIFIED MAIL-RETURN RECEIPT REQUESTED.