KENTUCKY
AGC Self Insurers' Fund

Policy Cancellation Request Form

The undersigned requests cancellation of the policy indicated below. The undersigned, by signing this Policy Cancellation Request Form, represents that he/she has the authority to request this cancellation action on behalf of the policyholder. Cancellations will be effective the date they are received by The Fund. Please note that cancellations CANNOT be backdated unless the circumstances listed below are warranted.

The undersigned agrees that 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 below.

The undersigned agrees that any premium adjustment will be made in accordance with the terms and conditions of the policy. ***All fields below are required for processing requests.***

Policyholder Name: _____

Policy Number: _____

Requested Date of Cancellation: _____

Reason for Cancellation: _____

Signature: _____

Print Name: _____

Title: _____

Phone Number: _____

Date: _____

If coverage was placed elsewhere, a Declarations page from the New Carrier reflecting policy effective date must be provided. If the business was sold and you are requesting to backdate you must provide signed proof of sale with corresponding date.

Please email the completed form to Julie.boston@agcsif.com

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502-415-7878