



Date \_\_\_\_\_ Page \_\_\_\_\_ of \_\_\_\_\_

**SBI SECTION**—List all person(s) or entity(ies) with a substantial beneficial interest in you as defined in the applicable policy provisions (including landlords or tenants insured under the applicant). If none, state NONE. Use the SSN / EIN Reporting form for additional space.

<b>APPLICATION</b> (Complete Section A)	<b>OTHER CHANGES FOR MPCJ POLICIES ONLY</b>		
<b>CANCELLATION</b> (Complete Section A and B)	Add or Remove SBI	Add/Change/Correct Insured's Authorized Representative	Change/Correct Insured's Address
<b>TRANSFER</b> (Complete Section A and C)	Correct Insured's Identification Number***	Correct Spelling of Insured's Name	Correct SBI's Identification Number***
	Correct Spelling of SBI's Name	***Enter Previous ID number if this item is checked:	

[illegible]

**\*\*In addition to my share on the policy. Attached is evidence of their approval (POA, Lease Agreement, etc.).**

**CONDITIONS OF ACCEPTANCE\*\*\*:**

YES	NO	(a)	Are you now indebted, and the debt is delinquent for crop insurance coverage under the Federal Crop Insurance Act?
YES	NO	(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?
YES	NO	(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 delinquent debt?
YES	NO	(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?
YES	NO	(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?
YES	NO	(f)	Do you have like insurance on any of the above crop(s)?

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.

\*\*\*THESE CONDITIONS ONLY APPLY TO MPC1 COVERAGE. THEY WILL NOT BE USED IN THE DETERMINATION OF COVERAGE FOR CROP HAIL COVERAGE.



# MPCI APPLICATION/CANCELLATION/TRANSFER/POLICY CHANGE WITH SCO/ECO/STAX

Producers Ag Insurance Group®, 5601 Interstate 40 W, Suite 204, Amarillo, TX 79106

Policy No. \_\_\_\_\_ Crop Year \_\_\_\_\_ Date \_\_\_\_\_ Page \_\_\_\_\_ of \_\_\_\_\_

## SUPPLEMENTAL COVERAGE OPTION ENDORSEMENT (SCO ENDORSEMENT) APPLICATION

### CROP INFORMATION

COUNTY NAME	CROP(S)	CROP YEAR	UNDERLYING PLAN OF INSURANCE	SCO PLAN OF INSURANCE	COVERAGE LEVEL	ENROLLED IN AGRICULTURE RISK COVERAGE (ARC)		COVERAGE PERCENTAGE~
						YES	NO	
						YES	NO	
						YES	NO	
						YES	NO	
						YES	NO	

**LEGEND: ~ Note:** select from 50 percent to 100 percent. The default coverage is 100 percent.

### TERMS AND CONDITIONS

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 Basis Provisions and applicable Crop Provisions to elect this Endorsement and must also purchase this Endorsement with the same Approved Insurance Provider (AIP) as my Common Crop Insurance Policy.
- (2) I may elect coverage under this Endorsement and the Farm Service Agency's Agriculture 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 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 crop insured under this Endorsement.

## ENHANCED COVERAGE OPTION ENDORSEMENT (ECO ENDORSEMENT) APPLICATION

### CROP INFORMATION

COUNTY NAME	CROP(S)	CROP YEAR	UNDERLYING PLAN	ECO PLAN OF	COVERAGE	AREA LOSS TRIGGER		COVERAGE
						90	95	
						90	95	
						90	95	
						90	95	
						90	95	

**LEGEND: ~ Note:** select from 50 percent to 100 percent. The default coverage is 100 percent.

### TERMS AND CONDITIONS

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

- (1) I must have purchased a policy under the Common Crop Insurance Policy Basis Provisions and applicable Crop Provisions to elect this Endorsement and must also purchase this Endorsement with the same Approved Insurance Provider (AIP) as my Common Crop Insurance Policy.
- (2) 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.
- (3) If at any time my Common Crop Insurance Policy for the crop is cancelled or terminated, coverage under this endorsement is automatically cancelled or terminated.
- (4) 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.
- (5) Separate Administrative Fees will be assessed for each crop insured under this Endorsement.

### CROP-HAIL / NAMED PERIL UNDERWRITING QUESTIONS

1. Have any of the crops listed above been previously damaged by a peril covered under the policy you are applying for? Yes No
2. Have you purchased or applied for other like insurance on the same crops? Yes No  
If "Yes" show Company Name and coverage: (1) \_\_\_\_\_ / \$/acre \_\_\_\_\_; (2) \_\_\_\_\_ / \$/acre \_\_\_\_\_

Crop hail coverage becomes effective as of the time and date stated in the crop hail provisions.

Note: For hail/named peril coverage applied for on this combination MPCI/Hail/NP application, all qualifying acres of the crop in the county will be covered. If you only want a portion of your acres covered, you should complete a separate Crop Hail/Named Peril application.



# MPCI APPLICATION/CANCELLATION/TRANSFER/POLICY CHANGE WITH SCO/ECO/STAX

Producers Ag Insurance Group®, 5601 Interstate 40 W, Suite 204, Amarillo, TX 79106

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## STACKED INCOME PROTECTION (STAX) APPLICATION

### CROP INFORMATION

CROP	EFFECTIVE CROP YEAR	INSURED COUNTY	DESIGNATED COUNTY	COMPANION POLICY PLAN OF INSURANCE (if applicable)	OPTIONS, ELECTIONS, OR ENDORSEMENTS	COVERAGE RANGE	PRACTICE	TYPE	AREA LOSS TRIGGER	STAX PLAN OF INSURANCE	STAX PROTECTION FACTOR

**SCO and/or ECO COVERAGE:**      **YES**      **NO**      If yes, identify by APH Database whether SCO, ECO, or STAX applies. If land is added to this operation after the Sales Closing Date and reported by the Acreage Reporting Date, such acreage will be covered by      **SCO**      **ECO**      **STAX**

### TERMS AND CONDITIONS

I may not elect coverage under this plan of insurance on the same acres I elect coverage for the Supplemental Coverage Option Endorsement (SCO) and/or the Enhanced Coverage Option (ECO) if I participate in the SCO and/or ECO. I am elect coverage under this plan of insurance and the Farm Service Agency's Agriculture Risk Coverage Program or Price Loss Coverage Program, but the same acreage of the crop cannot be covered under both programs. I understand that by signing this Application, the coverage under this plan of insurance 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.

### SECTION B - CANCELLATION

I hereby request cancellation of my crop insurance policy for the crop(s) and crop year shown on this cancellation. I understand that if this form is not executed on or before the cancellation date for any crop year listed, the cancellation of insurance on such crop(s) will not be effective until the following crop year.

REASON FOR CANCELLATION: (CHECK ONE)      Insured's Request      Mutual Consent      Death, Incompetence, or Dissolution      Other \_\_\_\_\_

\_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
AIP Representative's Printed Name      AIP Representative's Signature      Date

### SECTION C - TRANSFER

CROP(S) TO BE CANCELED AND TRANSFERRED:

CROP YEAR OF CROPS BEING CANCELED AND TRANSFERRED:

**CANCELLATION / TRANSFER OF EXPERIENCE INFORMATION** - To be completed if canceling previous policy with another insurance provider.

**POLICY CANCELLATION / TRANSFER INFORMATION:** I hereby request cancellation of my insurance policy with (Ceding AIP Name and Policy Number) \_\_\_\_\_ for the crop(s) and crop year(s) shown above 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.

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

\_\_\_\_\_      \_\_\_\_\_  
Ceding Approved Insurance Provider      Assuming Approved Insurance Provider

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.

\_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
AIP Representative's Printed Name      AIP Representative's Signature      Date

### REMARKS:



# MPCI APPLICATION/CANCELLATION/TRANSFER/POLICY CHANGE WITH SCO/ECO/STAX

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## SIGNATURE AUTHORIZATION

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.

The authority granted under this provision: a) is applicable only to the insured person and insured commodities reported on this Application and does not extend to any other policy or person; b) terminates upon (i) our receipt of a new Application for the commodities reported on this Application, (ii) voidance or termination of the policy for any reason, including dissolution, death, disappearance or judicially declared incompetence of the grantor, (iii) legal separation or divorce if the authorized person is a spouse of the insured person; and c) does **not** extend to changing plans of insurance or applying for new coverage, including but not limited to, adding a new crop to an existing policy.

It is your sole responsibility to notify any other persons that have authority to sign on your behalf, including persons authorized to act on your behalf under a power of attorney, that you are granting authority to other person(s) to sign crop insurance documents. You shall be liable for all damages that result from your authorizing more than one person to act on your behalf with respect to your multiple-peril crop insurance policy. In accepting your application and the grant of authority contained therein ProAg does not waive or vary any federal or state law. ProAg will not be held liable if the granting of authority under this Signature Authorization language is determined to be invalid under state or federal law or is superseded by any grant of authority under a valid power of attorney.

Legal Name	Last 4 SSN

I extend the above grant of authority, subject to all terms and conditions above, to all SBI holders listed on this application without needing to list them in this section.

**Note:** If you only want certain SBI holders to have signing authority, they should be listed above. However, all SBI holders must be listed in the appropriate section of this application; listing a person in this section does **not** satisfy the application's requirement to list all SBI holders.

I hereby revoke the authority to sign crop insurance documents on behalf of the insured that was previously granted to the following person(s):

Legal Name

By signing below, I authorize the Company to offset from any indemnity or prevented planting payment any and all unbilled and payable premium and fees.

Check here only if you do **NOT** authorize such offset.

## REQUIRED STATEMENTS FOR CROP HAIL POLICIES BY STATE:

**ARKANSAS and LOUISIANA**—WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**ARIZONA**—For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**CALIFORNIA**—For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**COLORADO**—It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**FLORIDA**—Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**IDAHO**—Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**INDIANA**—Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**KANSAS** - Any act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, impulsive, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for the personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto is considered fraud.

**KENTUCKY**—Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

**MARYLAND**—WARNING: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**MAINE**—WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

**MINNESOTA**—A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**NEW JERSEY**—Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NEW MEXICO**—WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**OHIO**—Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud

**OKLAHOMA**—WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**PENNSYLVANIA**—WARNING: Any person who knowingly, and with intent to defraud any insurance company or other person files any application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**TENNESSEE, VIRGINIA, and WASHINGTON**—It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, or a denial of insurance benefits.

**UTAH**—Any matter in dispute between you and the company may be subject to arbitration as an alternative to court action pursuant to the rules of the American Arbitration Association, a copy of which is available on request from the company. Any decision reached by arbitration shall be binding upon both you and the company. The arbitration award may include attorney's fees if allowed by state law and may be entered as a judgment in any court of proper jurisdiction.

**For All Other States:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.



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Policy No. \_\_\_\_\_ Crop Year \_\_\_\_\_ Date \_\_\_\_\_ Page \_\_\_\_\_ of \_\_\_\_\_

## 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.

## NON-DISCRIMINATION STATEMENT

In accordance with Federal law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating on the basis of race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income is derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs).

### 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 [www.ascr.usda.gov/ad-3027-usda-program-discrimination-complaint-form](http://www.ascr.usda.gov/ad-3027-usda-program-discrimination-complaint-form), or at 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, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov).

### Persons with Disabilities

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the responsible State or local Agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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.

## 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/Insured's Printed Name

Applicant/Insured's Signature

Date

Agent's Printed Name

Agent's Signature

Agent Code Number

Date