FLORIDA OFFICE OF INSURANCE REGULATION
REPORT OF RESCINDED POLICY

RETURN THIS COMPLETED FORM TO:

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS UNIT
ROOM 220, LARSON BUILDING
TALLAHASSEE, FL 32399-4210

DATE SUBMITTED _____

COMPANY FEDERAL ID# _____
FULL COMPANY NAME _____
POLICY HOLDER'S NAME _____
DATE OF APPLICATION FOR COVERAGE _____
POLICY NUMBERS _____

HAS A CLAIM BEEN FILED ON THIS POLICY YES _____ NO _____

IF YES:

CLAIM NO _____ DATE _____

CLAIM NO _____ DATE _____

CLAIM NO _____ DATE _____

CLAIM NO _____ DATE _____

DATE OF RECISSION OF THIS POLICY _____

OIR-B3-493
REV. 7/2006

THE FOLLOWING MUST BE RETAINED FOR THREE (3) CALENDAR YEARS FROM THE DATE SUBMITTED TO THE DEPARTMENT OF INSURANCE:

1. REPORT OF RESCINDED POLICY
2. INITIAL APPLICATION
3. COPY OF POLICY
4. COPY OF CLAIMS FORMS FILED
5. ALL DOCUMENTATION USED AS A BASIS FOR RESCISSION
6. NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF ANY INDEPENDENT CLAIMS ADJUSTING SERVICE WHERE FILES MAY BE LOCATED