



STATE OF NEW YORK  
INSURANCE DEPARTMENT  
25 BEAVER STREET  
NEW YORK, NEW YORK 10004

**TO BE COMPLETED BY INSURER:**

Name and Address of Insurer:

Contact Person:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Telephone Number:  
\_\_\_\_\_

Date: \_\_\_\_\_

Subject and Description of Filing:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE INCLUDE SELF-ADDRESSED STAMPED RETURN ENVELOPE**

**TO BE COMPLETED BY INSURANCE DEPARTMENT:**

Received by: \_\_\_\_\_

Date: \_\_\_\_\_

Department File Number: \_\_\_\_\_

**The following information is provided if available at time of receipt:**

File Assigned To: \_\_\_\_\_ Telephone Number: 212-480-\_\_\_\_\_

Date Assigned: \_\_\_\_\_