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: _____