SERVICE REQUEST FORM

TO: INDIANA DEPARTMENT OF INSURANCE
ATTN: LICENSING DIVISION
311 WEST WASHINGTON STREET
INDIANAPOLIS, INDIANA 46204-2787

FAX: 317-234-5882

EMAIL: AGENTLICENSING@IDOI.IN.GOV

FROM:

Name of Individual or Business Entity:				
Mailing Address (Street/PO Box):				
City:	State:	Zip:	SSN/FEIN:	License #:

MUST COMPLETE ALL THREE PARTS OF FORM AND SIGN BACK OF FORM WHERE SHOWN

PART ONE: OPTIONS
(select all that apply)

- ☐ 1. Change of Legal Name
- ☐ 2. Add/Remove Alias/Other Name
- ☐ 3. Correct Social Security Number or FEIN or Date of Birth
- ☐ 4. Change of Resident Address and/or Phone Number
- ☐ 5. Change of Business Address, Phone Number, and/or Fax
- ☐ 6. Request Letter of Clearance
- ☐ 7. Request Cancellation of License
- ☐ 8. Request Duplicate License – *fee required*
- ☐ 9. Add/Remove DRLP/Owner/Officer/Director
- ☐ 10. Change/Add E-mail Address

PART TWO: INFORMATION REQUIRED
(complete corresponding section based on options selected in Part One)

1. ☐ **CHANGE OF LEGAL NAME (**Must attach copy of official legal documentation showing how and why name was changed, such as, for individuals, a marriage certificate, divorce decree, or court order showing name change, or, for business entities, a Certificate of Amendment or other signed documentation from the Secretary of State. Copies of driver's licenses, SSN cards, or other ID's will NOT be accepted.)

_____ _____
Current Name on Record (Last, First, Middle) New Name to Appear on Record (Last, First, Middle)

2. ☐ **ADD/REMOVE ALIAS/OTHER NAME** *Must notify IDOI before conducting business under name. Business entities must supply copy of Certificate of Amendment or other signed document from Secretary of State.*

	(Check One)		(Check One)			
NAME	*Add*	*Remove*	*Assumed Business Name / DBA*	*Also Known As*	*Former Name*	*Other (specify type below)*
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	

3. ☐ **CORRECT SOCIAL SECURITY NUMBER or FEIN or DATE OF BIRTH TO:**
(Must attach copies of at least two (2) forms of identification confirming the number you provide below)

_____

4. ☐ **CHANGE OF RESIDENT ADDRESS AND/OR PHONE NUMBER** ☐ (check if this is Mailing address also)
State law requires you to notify the Department of a change of name or address within thirty (30) days of the change. Failure to do so will result in a $100.00 penalty, revocation, suspension, or other disciplinary action. **If moving from one state to another, submitting this form does NOT change your license residency. You must submit a new application and application fee to be issued a new resident or non-resident license.**

PRIOR RESIDENT ADDRESS (required)			**NEW RESIDENT ADDRESS (required)**		
Street Address:			Street Address:		
PO Box (if applicable):			PO Box (if applicable):		
City:		State:	City:		State:
Zip:	Phone Number:		Zip:	Phone Number:	

5. ☐ **CHANGE OF BUSINESS ADDRESS, PHONE NUMBER, OR FAX** ☐ (check if this is Mailing address also)
State law requires you to notify the Department of a change of name or address within thirty (30) days of the change. Failure to do so will result in $100.00 penalty, revocation, suspension, or other disciplinary action.

PRIOR BUSINESS ADDRESS (required)			NEW BUSINESS ADDRESS (required)		
Business Name:			Business Name:		
Street Address:			Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone Number:	Fax:		Phone Number:	Fax:	

6. ☐ **REQUEST LETTER OF CLEARANCE**
This request will surrender/inactive your resident Indiana license. **If moving from one state to another, submitting this form does NOT change your Indiana license residency. You must submit a new application and application fee to be issued a new resident or non-resident Indiana license.**

I have moved from Indiana to the State of _____. Please cancel all my existing Indiana resident licenses and send me a Letter of Clearance.

7. ☐ **REQUEST CANCELLATION OF LICENSE**
Please note line(s) of authority to cancel if not cancelling all lines:_____
By signing this document licensee attests to no longer sell, solicit, negotiate or otherwise do business in the state of Indiana for the cancelled line(s). A licensee is allowed to continue with a license regardless of who paid the fees during the course of employment. Cancellation of an individual license is the decision of the individual, not the individual's employer. If the individual leaves employment, the individual may retain the license as long as requirements are met. **Should the individual or business entity require the cancelled line(s) in the future, they must complete all initial licensing requirements for the cancelled line(s).**

8. ☐ **REQUEST DUPLICATE LICENSE ($10.00 FEE REQUIRED FOR EACH DUPLICATE LICENSE)**
The fee for a duplicate license is $10.00 (personal check, cashier's check, or money order made payable to ***Indiana Department of Insurance***). Do NOT send cash. Requests will not be processed unless fee received.

License Number	Reason for Request

9. ☐ **ADD/REMOVE DESIGNATED RESPONSIBLE LICENSED PRODUCER or OWNER/OFFICER/DIRECTOR**

		(Check One)		(Check One)	
Name and Title	**License Number**	*Add*	*Remove*	*DRLP*	*Own/Off/Dir*
		☐	☐	☐	☐
		☐	☐	☐	☐

10. ☐ **CHANGE/ADD EMAIL ADDRESS**

Change/Add Business Email Address to: _____

Change/Add Personal Email Address to: _____

PART THREE: SIGNATURE/ATTESTATION
(Must be signed by individual licensee or Designated Responsible Licensed Producer (DRLP) of business entity)

I certify that all information provided is true and correct. I understand that any omission, false statement or failure to make full disclosure constitutes grounds for denial of request and/or denial, suspension, or revocation of license.

_____ _____
Signature of Individual Licensee or DRLP of Business Entity — Date

_____ _____
Print/Type Name of Individual Licensee or DRLP of Business Entity — Contact Email