Change Limits Request

Please Change my policy limits to:

□ **100/300K** □ **500/500K** □ **1M/1M** □ **1M/3M** □ **2M/4M** □ **10K/30K Florida ONLY**

Reason for change request: _____

Requested date for Change _____
*Any requested change regardless of date requested within the last 60 days of your policy will be effective upon your renewal unless otherwise approved.

NO MATERIAL CHANGE AND NO KNOWN LOSS WARRANTY
The First Named Insured, through its duly authorized representative below, acting on behalf of itself and on behalf of all other insured's, hereby warrants to Allied Professional's Insurance Services (APIS) that:

(1) Subsequent to the execution of the most recent Application submitted to APIS, there has been no additional information or changes to such Application including, but not limited to, the addition of any exposure(s), claim(s) and/or suit(s) and

(2) the insured's have no knowledge of any occurrence, offense, incident, medical incident, act, error or omission, wrongful act or circumstance [hereinafter, referred to as an **incident(s)**] which reasonably could give rise to a claim or suit under the proposed policy to be issued by APIS to the First Named Insured (hereinafter, referred to as the **proposed policy**), whether or not such **incident(s)** have been submitted to or accepted as covered by another insurer of any party to be insured under the **proposed policy**.

By signing below the Undersigned agrees that he/she is a duly authorized representative of the First Named Insured, warrants that the above statements are true, correct and complete, and acknowledges that, notwithstanding any other provision of the **proposed policy** to the contrary, APIS is relying upon these statements in issuing the **proposed policy**.

PAYMENT FOR ANY CHANGE REQUEST
Changes I may request be made to my policy may cause a change to my premium. Example: Change in location, change in limits of liability, adding an additional insured etc**.*If additional Premium is due**: I authorize my credit card or bank account listed on my auto debit form to be charged for the above request. AAC will automatically process the payment on file. If policyholder payment information is NOT available, or, where third party payment information exists, you will be contacted directly by a representative. (Payment is due no later than 72 business hrs. - to process your request). If you have an upcoming renewal, and received your renewal packet, it may be necessary to revise your renewal if the rate differs, based upon any changes. Once completed, we will email/fax your updated proof of insurance.

_____
Print Name of Insured Clearly

_____
Signature of Insured

_____
Date

Fax: 714-571-1863
Email: info@acupuncturecouncil.com

Credit Card/ACH Payment Authorization Form

Credit/ Debit Card: 

Cardholders Name: _____

Account Number: _____ Expiration Date: _____

Billing Address: _____

City / State / Zip: _____

Checking or Saving Account:

Bank Name: _____

Routing Number: _____

Account Number: _____

City / State: _____

For one-time payment: I acknowledge that I am the accountholder or have authorization to use this credit/debit card or bank account for a one-time payment. I hereby request and authorize to charge the credit/debit card or bank account listed above for the current premium due. This authorization is only valid for the current premium due and does not apply to any future payments due.

Name: _____ **Date**: _____

Fax or Email To:

Fax: (714) 571 – 1863 Email: info@acupuncturecouncil.com