Producers Ag Insurance Group®
2025 South Hughes, Suite 200, Amarillo, TX 79109

ASSIGNMENT OF INDEMNITY

Date _____ Page _____ of _____

An insured may assign the right to an indemnity for a crop(s) under a policy to a creditor(s) or other persons to whom the insured has a financial debt or other pecuniary obligation by using an Assignment of Indemnity. The assignment(s) applies for all acreage of the covered by the policy.

Dairy Revenue Protection: The assignment(s) applies for all liability remaining on the crop covered by the policy at the time the assignment is accepted by the Approved Insurance Provider.

INSURED'S NAME:			AGENCY:	AGENCY CODE:		EFFECTIVE CROP YEAR / POLICY NUMBER:
STREET AND/OR MAILING ADDRESS:			ADDRESS:			STATE / COUNTY:
CITY:	STATE:	ZIP CODE:	CITY:	STATE:	ZIP CODE:	CROP(S):
PHONE:			PHONE:			PLAN OF INSURANCE / COVERAGE / % OF PRICE:
IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER TYPE:	PERSON TYPE:	INSURED'S AUTHORIZED REPRESENTATIVE: (Mailing Address)			

The Insured

assigns to _____ of _____
(Name of Creditor)

_____
(City, State, Zip)

the right and interest of any indemnity payment(s) which may be payable to the insured under the insurance policy for the county/commodity(ies) shown.

CONDITIONS

1. This assignment will be binding upon the person(s) who succeed the insured's interest in the insurance policy.
2. Indemnity payments made under the insurance policy will be subject to a deduction for any indebtedness due this Approved Insurance Provider by the Insured.
3. This assignment will not grant the Creditor any greater rights than originally held by the Insured.
4. The Creditor's interest will be recognized upon Approved Insurance Provider's approval of this assignment and the Creditor will have the right to submit the loss notices and other forms as required by the insurance policy.
5. The Approved Insurance Provider will determine the person(s) entitled to an indemnity payment(s) and the payment(s) will be by joint check.
6. Cancellation of this assignment prior to and during the crop year stated above will be accepted by the Approved Insurance Provider only once notification in writing by the above identified Creditor(s). It is understood and agreed that this assignment will be subject to the terms and conditions of the insurance policy.
7. If the assignment is not canceled according to item (6), the assignment will cease at the end of the effective crop year.

Version 5.0
Updated: August 17, 2018

PROAG-16062

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Policy Number: _____ Effective Crop Year: _____ Date _____ Page _____ of _____

COLLECTION OF INFORMATION AND DATA (PRIVACY ACT) STATEMENT
Agents, Loss Adjusters and Policyholders

The following statements are made in accordance with the Privacy Act of 1974 (5 U.S.C. 552a): The Risk Management Agency (RMA) is authorized by the Federal Crop Insurance Act (7 U.S.C. 1501-1524) or other Acts, and the regulations promulgated thereunder, to solicit the information requested on documents established by RMA or by approved insurance providers (AIPs) that have been approved by the Federal Crop Insurance Corporation (FCIC) to deliver Federal crop insurance. The information is necessary for AIPs and RMA to operate the Federal crop insurance program, determine program eligibility, conduct statistical analysis, and ensure program integrity. Information provided herein may be furnished to other Federal, State, or local agencies, as required or permitted by law, law enforcement agencies, courts or adjudicative bodies, foreign agencies, magistrate, administrative tribunal, AIP's contractors and cooperators, Comprehensive Information Management System (CIMS), congressional offices, or entities under contract with RMA. For insurance agents, certain information may also be disclosed to the public to assist interested individuals in locating agents in a particular area. Disclosure of the information requested is voluntary. However, failure to correctly report the requested information may result in the rejection of this document by the AIP or RMA in accordance with the Standard Reinsurance Agreement between the AIP and FCIC, Federal regulations, or RMA-approved procedures and the denial of program eligibility or benefits derived therefrom. Also, failure to provide true and correct information may result in civil suit or criminal prosecution and the assessment of penalties or pursuit of other remedies.

NON-DISCRIMINATION STATEMENT

Non-Discrimination Statement:
In accordance with Federal law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating on the basis of race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income is derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs).

To File a Program Complaint:
If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at https://www.ascr.usda.gov/ad-3027-usda-program-discrimination-complaint-form, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter by mail to the U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or email at program.intake@usda.gov.

Persons with Disabilities:
Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the responsible State or local Agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

Persons with disabilities, who wish to file a program complaint, please see information above on how to contact the Department by mail directly or by email.

PRODUCERS AG INSURANCE GROUP PRIVACY NOTICE

The Producers Ag Insurance Group (ProAg Group) is committed to respecting the individual privacy of our policyholders and their significant beneficial interest owners (Customers). We collect nonpublic personal information about Customers from information we receive from them such as information provided on applications or other forms, which may include name, address and social security numbers and from third parties such as a consumer reporting agency. To serve our customers and to service our business our employees have access to Customers personal information in the course of doing their jobs and we may share or disclose non-public personal information about the Customers to affiliates within the ProAg Group or with non affiliated third parties with whom we have a contractual relationship such as agencies within the united States Department of Agriculture, with your insurance agent and other insurance companies or with banks where a written permission to transfer such information has been granted by the policyholder. We may also share non-public personal information with affiliates and with non-affiliated third parties as permitted by law. The ProAg Group will not sell or share your personal information with anyone for purposes unrelated to our business functions with out our offering to the Customer the opportunity to "opt-out" or to "opt-in" as required by law.

Insured's Printed Name	Insured's Signature	Date	Creditor's Authorized Representative's Printed Name	Creditor's Authorized Representative's Signature	Date	Creditor's Authorized Representative's Telephone Number

Witness' Printed Name	Witness' Signature	Date	Witness' Printed Name	Witness' Signature	Date

The Approved Insurance Provider hereby approves the foregoing assignment.

Approved Insurance Provider's Authorized Representative's Printed Name	Approved Insurance Provider's Authorized Representative's Signature	Date

This assignment was filed with the Approved Insurance Provider on _____ (Month, Day, Year) at _____ (Hour) AM/PM