

REINSTATEMENT REQUEST FORM
For Idaho State Program Participants

Policy: 10 EO 0014ID

Expiration Date of Previous Coverage: October 1, 2010
Or Requested Coverage Date: _____

Please select coverage type: Firm License or Individual License

Name: _____

Firm: _____

Firm Address: _____

Business Phone: (____) _____ - _____ Home Phone: (____) _____ - _____ Fax: (____) _____ - _____

Social Security Number: _____ - _____ - _____ License #: _____

E-Mail Address: _____

Please state reason for requested reinstatement:

I, the undersigned, certify that as of the current date **I have no knowledge of any claims which have been made against the entity or individual for which insurance is requested since the date of expiration listed above.** I, the undersigned, also certify that as of the current date **I have no knowledge of any negligent acts, errors or omissions or related negligent acts, errors or omissions committed or alleged to have been committed prior to the current date,** that may reasonably be expected to become the basis of a claim against the entity or individual for which insurance is requested. I, the undersigned, certify that **I understand that the reinstatement procedure does not impact my failure to comply with the mandatory insurance guidelines established by the Commission and I may still be subject to penalties and fines by the Commission.**

Signature of individual licensee applicant
Or for firm licensees, the firm representative

Current date

Mailing Address: **P.O. Box 6709, Louisville, KY 40206-0709**
Overnight Address: 4211 Norbourne Blvd, Louisville, KY 40207-4048

Toll-free: (800) 637-7319 Local: (502) 897-1876 Fax: (502) 897-7174 Website: www.risceo.com