

Continental Casualty Company  
Real Estate Errors and Omissions Insurance

Administered by Rice Insurance Services Company, LLC

**REINSTATEMENT REQUEST FORM**  
**For North Dakota State Program Participants**

Policy: 12 EO 0011ND

Expiration Date of Previous Coverage: January 1, 2012  
Or Requested Coverage Effective Date: \_\_\_\_\_

**Print or type**

Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ License #: \_\_\_\_\_

Business Phone: ( ) - \_\_\_\_\_ Home Phone: ( ) - \_\_\_\_\_ Fax: ( ) - \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Firm Legal Name: \_\_\_\_\_ D/B/A: \_\_\_\_\_

Firm Address: \_\_\_\_\_

Broker Name: \_\_\_\_\_ Broker 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, 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

\_\_\_\_\_  
Current date

Please include this form with payment to RISC:  
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