

Voluntary Surrender Request Form *Use a separate form for each licensee. Forms will not be held for a future date. Forms will be processed as received.*

Form must be completed, signed and dated by the licensee or authorized representative of an insurance agency.

Required Information about the Licensee

Insurance Licensee Last Name or Insurance Agency Name	First Name	Middle Name or Initial	Suffix (Jr, Sr, I, II, etc.)
Michigan System ID (License) Number	National Producer Number		

By checking this box, I understand that I am voluntarily surrendering my entire Michigan insurance license as selected.

Select the appropriate license type/types below to surrender your entire Michigan insurance license/licenses.

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> Producer – Individual or Agency | <input type="checkbox"/> Insurance Adjuster | <input type="checkbox"/> Solicitor |
| <input type="checkbox"/> Surplus Lines – Individual or Agency | <input type="checkbox"/> Adjuster for the Insured | <input type="checkbox"/> Counselor |

By checking this box, I understand I will maintain my Michigan insurance producer license but surrender the selected lines of authority.

Select only the line/lines of authority you want to surrender.

- | | | |
|---|--|---|
| <input type="checkbox"/> Life | <input type="checkbox"/> Accident & Health | <input type="checkbox"/> Variable Annuities |
| <input type="checkbox"/> Limited Life | <input type="checkbox"/> Property | <input type="checkbox"/> Casualty |
| <input type="checkbox"/> Personal Lines | <input type="checkbox"/> Limited Lines P & C | <input type="checkbox"/> Title |
| <input type="checkbox"/> Other _____ | | |

Attestation of Individual Licensee – or Designated Responsible Licensed Producer, Director, Member, Officer, Owner, Partner, or Stockholder for a Business Entity (Agency)

By signing this request, I swear under penalty of perjury that I will no longer attempt to operate as a licensee for the specified line(s) of authority in the State of Michigan. I also swear under penalty of perjury that if the license document is in my possession, I agree to immediately destroy it. I certify that the information given on this form is complete and correct.

Signature	Signer's Title (for a Business Entity/Agency)	
	<input type="checkbox"/> DRLP <input type="checkbox"/> Director <input type="checkbox"/> Member <input type="checkbox"/> Officer <input type="checkbox"/> Owner <input type="checkbox"/> Partner <input type="checkbox"/> Stockholder	
Signer's Name (type or print clearly)	Email address (required)	Date Signed

Submit completed form by mail to DIFS Insurance Licensing, PO Box 30220, Lansing MI 48909-7720; by fax to 517-284-8836; or attach to an email and send to DIFS-Licensing@michigan.gov