

E. Assignment of Indemnity:

**APPLICATION FOR
ASSIGNMENT OF INDEMNITY**

CROP YEAR 1.	AGENCY NAME 5.		
POLICY NO. 2.	AGENCY CODE 6.		
COUNTY 3.	AGENCY ADDRESS 7.		
COMMODITY(S) 4.	CITY 8.	STATE	ZIP

INSURED INFORMATION (Please Print)			LENDER OR CREDITOR (herein "Lender")		
NAME 9.			NAME 14.		
SOCIAL SECURITY/TAX I.D. # 10.					
ADDRESS 11.					
CITY 12.	STATE	ZIP	ADDRESS 15.		
INSURED'S AUTHORIZED REPRESENTATIVE 13.			CITY 16.	STATE	ZIP

The undersigned Insured assigns to the Lender the right and interest of any indemnity payment(s) which may be payable to the insured under the insurance policy for the commodity(s) and crop year shown above.

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 insurance provider by the Insured.
- 3) This assignment will not grant the Lender any greater rights than originally held by the Insured.
- 4) The Lender's interest will be recognized upon insurance provider's approval of this assignment and the Lender will have the right to submit the loss notices and other forms as required by the Policy.
- 5) The insurance provider will determine the person(s) entitled to any indemnity payment(s) and the payments(s) will be by joint check.
- 6) Cancellation of this assignment prior to the crop year stated above will be accepted by the insurance provider only upon notification in writing by the above identified Lender.

It is understood and agreed that this assignment will be subject to the terms and conditions of the insurance policy.

Signature of Insured/Authorized Representative 17.	Date	Signature of Lender 18.	Date
WITNESS SIGNATURE 19.	Date	WITNESS SIGNATURE 20.	Date

FILING				APPROVAL			
This assignment was filed with the insurance provider on				The insurance provider hereby approves the foregoing assignment.			
21. (Date, Year)	a t	22. (Hour)	a.m. p.m.				
				Company Name 23.			
				Signature of Insurance Provider/Authorized Representative 24.			Date
				Address 25.			

SEE REVERSE SIDE OF FORM FOR STATEMENT REQUIRED BY PRIVACY ACT OF 1974

LGM Assignment of Indemnity