STATE OF CALIFORNIA
Form 31A-9 (Rev. 12/94)

DEPARTMENT OF INSURANCE
320 Capitol Mall, 1st Floor
SACRAMENTO, CA 95814

PERSONAL IDENTIFICATION INFORMATION

THIS FORM IS REQUIRED TO BE COMPLETED BY THE FOLLOWING PERSONS AFFILIATED WITH A LICENSED ADJUSTER:

Each partner of a Partnership
Each officer of a Corporation
The Qualified Manager of an (Independent) Insurance Adjuster unless such Qualified Manager is an individual owner who is also applying for an adjusters' license.

ITEM (10) MUST BE COMPLETED BY THE LICENSED ADJUSTER WITH WHOM YOU ARE TO BE AFFILIATED.

1 TYPE: (Check only one) ☐ (INDEPENDENT) INSURANCE ADJUSTER ☐ PUBLIC INSURANCE ADJUSTER

2 POSITION: ☐ QUALIFIED MANAGER ☐ PARTNER OF PARTNERSHIP
☐ OFFICER OF CORPORATION, check one: ☐ PRESIDENT ☐ SECRETARY ☐ VICE PRESIDENT ☐ TREASURER

3 NAME: _____
(Last) (First) (Middle)

4 RESIDENCE ADDRESS (P.O. Box is not acceptable)

Street _____ Apt/Suite # _____

City _____ State _____ Zip _____

5 IDENTIFICATION INFORMATION:

▶ ATTACH A RECENT 1¼" x 1¼" PHOTOGRAPH:

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Sex ___ Male ___ Female Birth Date _____

Birthplace _____

Height _____ Weight _____ Eye Color _____ Hair Color _____

6 QUALIFIED MANAGER ONLY:

A. Examination Information (if applicable): Desired examination location _____ (Los Angeles, San Diego, San Francisco, Fresno, Sacramento). You will be scheduled for the next available date in the location selected.

B. Fingerprint impressions and a fingerprint processing fee are required for the qualified manager. If an examination is is required, your fingerprint impressions will be taken at the examination site upon passing the examination.

C. Do you now hold, or have you ever held any license/permit under which you engaged in any occupation? . . . . . ☐ YES ☐ NO
If "YES," list such license/permit:

_____

D. List your occupation/employment for the past five years to current date. Include unemployment and school.

NOTE — IF YOUR EMPLOYMENT RECORD IS TO BE USED TO DETERMINE YOUR EXPERIENCE ELIGIBILITY FOR THIS LICENSE, ATTACH A SEPARATE SIGNED STATEMENT DETAILING THE DUTIES PERFORMED AND THE TIME SPENT PERFORMING SUCH DUTIES.

From (Mo. & Yr.)	To (Mo. & Yr.)	Employer Name	Employer Address	Reason for Leaving

7 HAVE YOU EVER HAD ANY PROFESSIONAL, VOCATIONAL OR BUSINESS LICENSE DENIED, SUSPENDED, REVOKED OR RESTRICTED OR A FINE IMPOSED BY ANY PUBLIC AUTHORITY, OR WITHDRAWN ANY APPLICATION FOR OR SURRENDERED ANY SUCH LICENSE TO AVOID DISCIPLINARY ACTION? . . . . . ☐ YES ☐ NO

8 HAVE YOU EVER BEEN CONVICTED OF A CRIME? . . . . . ☐ YES ☐ NO

"Crime" includes a felony or misdemeanor and military offenses. "Convicted" includes, but is not limited to, having been found guilty by verdict of a judge or jury, having entered a plea of nolo contendere, having had any charge dismissed or plea withdrawn pursuant to Penal Code Section 1203.4, or having been given probation, a suspended sentence or a fine. You may exclude traffic citations and juvenile offenses.

▶ **IMPORTANT NOTICE:** If you answered yes to (7) or (8), attach a detailed statement, signed by you, of the events which led to the charges (dates and places). If the matter was heard in court, attach copies, CERTIFIED BY THE COURT, of the **Criminal Complaint** and the Sentencing Minute Order showing the final judgment.

9 **STATEMENT AND CERTIFICATION:**

I represent that my affiliation with the adjuster named in (10), below, is not prohibited by the laws, rules or regulations of any Federal, State, County, or municipal Government by which I am currently employed (if any), or by which my employer or I am licensed, (if any).

I Certify under penalty of perjury that I have read the foregoing information provided and know the contents thereof and that each statement therin made is full, true and correct, and I agree to notify the Insurance Commissioner of any change in the information provide by me. I understand that any false statement may subject the license to denial or subsequent revocation. Further, pursuant to Insurance Code Section 15028.6 and Government Code 7473, I authorize disclosure to the Insurance Commissioner of all financial institution records of any Fiduciary Accounts for the duration of the license.

▶ SIGNATURE _____ CITY _____ DATE _____

RESIDENCE PHONE # ( ) _____ BUSINESS PHONE # ( ) _____

10 **THE FOLLOWING MUST BE COMPLETED *BY THE LICENSED ADJUSTER* WITH WHOM YOU WILL BE AFFILIATED:**

A. Adjusters' Name (as shown on license): _____ License # _____

B. Is the person named in question (3) **REPLACING** a previously named Qualified Manager, Officer, or Partner? . . . . . ☐ YES ☐ NO

If **Yes**, complete the following: Date previously named person left the position: _____/_____/_____

List below the name, title, and Social Security Number of the previously named person. That person's Pocket Identification Card, if any, must be returned to the Department along with this form.

Name: _____ Title _____ SSN ____/____/____
Last First Middle

▶ As authorized, I certify the statements made in this Personal Identification form are true and correct and declare that the person named in (3) will act in the position as shown in question (2).

▶ Signature of licensed Adjuster: _____ Title _____ Date _____
If an Adjuster is an organization, an officer of the corporation or a partner of the partnership must sign.