MAILING ADDRESS:
State of California
DEPARTMENT OF INSURANCE
P.O. Box 1139
Sacramento, CA 95812-1139

- FOR DEPARTMENT USE ONLY -

EFFECTIVE DATE IS DATE SIGNED, UNLESS VALIDATED OTHERWISE OR MARKED VOID BY THE DEPARTMENT.

SOLICITOR SELF TERMINATION NOTICE

ATTACH FILING FEE
Form 417-32 (Rev. 7/95)

(TO BE FILED IN TRIPLICATE)
Pursuant to Sections 1704 and 1707 of the Insurance Code

TO THE INSURANCE COMMISSIONER OF THE STATE OF CALIFORNIA:

Notice is hereby given that effective from date of filing this notice, I, as the Solicitor, hereby TERMINATE my appointment of employment made by the named employer.

EMPLOYER INFORMATION

ENTER EMPLOYER'S LICENSE NUMBER:

EMPLOYER'S NAME

MAILING ADDRESS

CITY, STATE AND ZIP CODE

SOLICITOR INFORMATION

ENTER SOLICITOR'S LICENSE NUMBER:

SOLICITOR'S NAME

MAILING ADDRESS

CITY, STATE AND ZIP CODE

SOLICITOR'S SIGNATURE

▶

DATE: *MONTH* *DAY* *YEAR*

PHONE NUMBER:

( )

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