AMERICAN
INDEPENDENT NETWORK
A Penn Treaty Company

tel 800.362.0700
fax 610.965.6962
www.penntreaty.com

REQUEST FOR DUPLICATE POLICY

Enclose a check or money order for $25.00, made payable to American Independent Network Insurance Company of New York.

PART 1: Policy Information

Policy Number: _____ Policyholder Name: _____

Date of Birth: _____ Last Four Digits of Policyholder's Social Security Number: _____

Policyholder Address: _____

City: _____ State: _____ ZIP Code: _____

NOTE: The duplicate policy will be mailed to the policyholder's address of record unless special instructions to mail the duplicate policy to another address are provided here: _____

PART 2: Declaration and Signature

"AINIC" refers to American Independent Network Insurance Company of New York.

By signing below, I declare that:

- The above-referenced policy was lost or destroyed.
- No person, firm or corporation has or claims the right to possession of the policy.

I request that AINIC issue a duplicate of the above-referenced policy numbered the same as the original. I understand that the duplicate policy will reflect current coverage, including any requested changes, and may not be an exact replica of the original.

I understand that while every effort will be made to ensure the accuracy, correctness and completeness of the duplicate policy, AINIC, its owners, employees, agents, assigns and successors disclaim any and all liability for inadvertent errors or omissions (including typos) in any of the content, specifications or pricing. Actual plan coverage and benefit payment is determined when a claim is received.

In consideration of granting of this duplicate policy request without the surrender of the original policy:

- I agree that once the duplicate policy is issued, if the original policy is later found, I will return the original policy to AINIC.
- I release all liability and I agree to indemnify and hold AINIC harmless from any claims or expenses that may arise from the original policy or as a result of granting this request. This release and indemnification shall be binding upon my heirs, executors, administrators, successors and assigns.

_____ _____ _____

Print Name Signature Date

If this Declaration is signed by the policyholder's personal/legal representative, please complete the following:
Basis for representation (check one): ❑ Power of Attorney ❑ Guardian ❑ Other: _____

(ATTACH COPY OF LEGAL DOCUMENT IF NOT ALREADY ON FILE)