DEPARTMENT OF FINANCIAL SERVICES

Division of Rehabilitation and Liquidation
www.floridainsurancereceiver.org

For DFS purposes only;
_____Adjuster
_____date
_____Supervisor
_____date

Claimant Address Change Only Request

This information **must be completed** in order to identify your claim. If not received, this form will be mailed back to you for additional information and the processing of your request will be delayed.

Company in Liquidation: _____

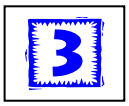
Claim #: _____

Policy #: _____

Receiver's ID#/Suffix: _____

Claimant Name and Address currently on file with Receiver:

Name:		
Address:		
City:	State:	Zip:



Please enter the new information in the box below and **attach the appropriate supporting documentation**. A copy of a valid driver's license, utility bill or passport reflecting the new information must be submitted. If claimant is a business and is not incorporated, document(s) to verify the new address, such as utility bill, occupational license, or bank statements should be submitted. If incorporated, a copy of most recent filing with Sec of State (www.sunbiz.org), or filing that reflects address change should be submitted.

Please return this form along with the supporting documentation to: **The Department of Financial Services, Division of Rehabilitation and Liquidation, Attention: Claims Dept – Change of Address, PO Box 110, Tallahassee, FL 32302-0110.**

Name:		
Address:		
City:	State:	Zip:
Phone #:		

I swear or affirm that I am the claimant referenced in the mailing address on this form and/or am authorized to sign this form on the claimant's behalf. I further swear under penalty of law that all information contained on this form as well as all attachments are true and correct to the best of my knowledge.

_____

Claimant Signature **Date**

_____

Relationship to Claimant