DEPARTMENT OF FINANCIAL SERVICES

Division of Rehabilitation and Liquidation
www.floridainsurancereceiver.org

For DFS purposes only;
_____Adjuster
_____Date
_____Supervisor
_____Date

Assignment of Claim Request Change Form

Company in Liquidation:	Claim #:
Policy #:	Receiver Claim Number (RCN)/Suffix:

Claimant name (you or your firm's name) and address currently on file with Receiver:

Claimant Name:		
Address:		
City:	State:	Zip:

By submitting this form, you or your firm are requesting that the Receiver's records for your claim be permanently changed to show that the person/entity entered below is the new owner of the title, interest and rights to your claim, including any future mailings and distributions if they occur. **Please note that no alterations can be made to the wording on this form and no part of the form can be obscured or redacted.**

New Owner Name:		
Address:		
City:	State:	Zip:
Phone #:	Email:	

With your signature, you acknowledge that it is your intent to sell your claim and that the purchase price of the claim may differ from the amount ultimately distributed in the Receivership proceeding with respect to the claim, and that such amount may not be absolutely determined until the conclusion of the Receivership proceeding. You further acknowledge and represent that you or your firm has adequate information concerning the business and financial condition of the estate of the claim and the status of the Receivership proceeding to make an informed decision regarding the sale of the claim and that you or your firm has independently made an analysis and decision to enter into the assignment.

Please have your signature notarized below and return this form along with the supporting documentation as outlined in the instructions to: The Department of Financial Services, Division of Rehabilitation and Liquidation, Attention: Claims Dept – Assignment of Claim, 2020 Capital Circle SE Suite 310, Tallahassee, FL 32301.

_____ _____

Claimant Signature **Date** **Relationship to Claimant**

I swear or affirm that I am the claimant referenced in the claimant name and address section of 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.

State of _____
County of _____

Sworn to and subscribed to me by _____ on this ____day of _____, 20___.

Notary Signature _____

Assignment of Claim Instructions

Support documents, as specified below, must accompany your request. The Receiver reserves the right to validate any change request received and may request additional information from you. Please contact us if you have questions by clicking on the "Contact Us Form" in the website's www.myfloridacfo.com/receiver navigation pane or you may call Consumer Services at 800-882-3054.

Assignments of claim will not be accepted after the distribution petition has been filed with the Court.

- Properly executed Assignment of Claim Change Request Form.
- Properly executed Claim Assignment Agreement.
- Forms must be signed and notarized with no information obscured, altered or redacted.
- If the claimant on file with the Receiver is not an individual, the change forms should be signed by an individual with the authority to sign on behalf of the company/corporation/drs office etc. If it is not a listed officer on the Secretary of States filing, supporting documentation confirming the person is authorized to act on the claimants behalf must be submitted.
- If the claimant name and/or address on file with the Receiver differs from the current claimant name and address, please see www.myfloridacfo.com/receiver for forms and instructions. This information must also be submitted with the Assignment of Claim Change Request Form and Claim Assignment Agreement.