



Claimant Address Change Only Request

Company in Liquidation:
Claim # if applicable:
Policy #:

Claimant Name and Address currently on file with Receiver or Insurance Company:

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 license, utility bill, passport or other photographic legal identification document that contains the address you have entered on your form.

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

Please sign below and return this form along with the supporting documentation via email or US mail to:

Email: checkprocessing@agfgroup.org

Florida Insurance Guaranty Association
Attention: Accounting Dept.
P.O. Box 14249
Tallahassee, FL 32317.

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.

Claimant Signature

Date

Relationship to Claimant