



DEPARTMENT OF FINANCIAL SERVICES

Division of Rehabilitation and Liquidation
www.floridainsurancereceiver.org

For DFS purposes only;
_____ Adjuster
_____ date
_____ Supervisor
_____ date

Claimant Name Change Request - With or Without Address Change



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 and legal documentation to support the change(s) (marriage certificate, divorce decree, legal orders, death certificate, corporate name change filing etc.) must be submitted. **Please have your signature notarized** in the space at the bottom of this form and return this form along with the supporting documentation to: **The Department of Financial Services, Division of Rehabilitation and Liquidation, Attention: Claims Dept – Change of Name/Address, PO Box 110, Tallahassee, FL 32302-0110.**

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



If you have assigned any rights to this claim to another party (i.e. assignment of interest), please enter the new party's information in the box below and attach a copy of the assignment. Please have your signature notarized in the space below and return this form to the address listed in the attached letter.

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
State of _____	Sworn to and subscribed to me by _____ on	
County of _____	this ____ day of _____, 20__.	_____
		Notary Signature