REINSTATEMENT REQUEST FORM
For Idaho State Program Participants

Policy: **09 EO 0013ID**

Expiration Date of Previous Coverage: **October 1, 2009**
Or Requested Coverage Date: ____________________

Please select coverage type: ☐ Firm License or ☐ Individual License

Name: ____

Firm: ____

Firm Address: ____

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Business Phone: ( ) - Home Phone: ( ) - Fax: ( ) -

Social Security Number: ______ - ______ - ______ License #: ____________________

E-Mail Address: __________________________

Please state reason for requested reinstatement:

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I, the undersigned, certify that as of the current date **I have no knowledge of any claims which have been made against the entity or individual for which insurance is requested since the date of expiration listed above.** I, the undersigned, also certify that as of the current date **I have no knowledge of any negligent acts, errors or omissions or related negligent acts, errors or omissions committed or alleged to have been committed prior to the current date**, that may reasonably be expected to become the basis of a claim against the entity or individual for which insurance is requested. I, the undersigned, certify that **I understand that the reinstatement procedure does not impact my failure to comply with the mandatory insurance guidelines established by the Commission and I may still be subject to penalties and fines by the Commission.**

______________________________ ______________________
Signature of individual licensee applicant Current date
Or for firm licensees, the firm representative

Mailing Address: **P.O. Box 6709, Louisville, KY 40206-0709**
Overnight Address: 4211 Norbourne Blvd, Louisville, KY 40207-4048

Toll-free: (800) 637-7319 Local: (502) 897-1876 Fax: (502) 897-7174 Website: www.risceo.com