

Application/Transfer/Change/Cancel Form

Applicant/Insured Information Name: _____ ID #: _____ Street or Mailing Address: _____ ID # Type: _____ City, State, Zip: _____ Person Type: _____ Phone #: _____ Spouse's Name: _____ Spouse's ID #: _____ Authorized Representative: _____ Is applicant at least 18 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No				Effective Policy Year: State: _____ County(ies): _____		Agency Information Agency Code: _____ Agent Name: _____ Agency Name: _____ Address: _____ City, State, Zip: _____ Phone #: _____ E-Mail: _____		Policy Number: NAU Country Insurance Underwriter: _____	
List all person(s) with a substantial beneficial interest in you as defined in the applicable policy provisions (including landlords or tenants insured under the applicant). If none, state "NONE". (see signature page for additional space or attach SSN/EIN Form)									
Existing Coverage					Change To Insurance Coverage <input type="checkbox"/>		Cancel Insurance		
Effective Policy Year	County	Plan of Insurance	Crop	Coverage Level	Coverage Level				
		Whole Farm Revenue Protection	<input type="checkbox"/> WFRP <input type="checkbox"/> Micro Farm				<input type="checkbox"/>		
Farm Taxes are filed as:			Insurance Options		Other Changes		Reasons for Cancellation		
Tax Year: <input type="radio"/> Calendar Year <input type="radio"/> Early Fiscal Year FY Start month: _____ <input type="radio"/> Late Fiscal Year FY Start month: _____			<input type="checkbox"/> Substitution <input type="checkbox"/> Exclusion <input type="checkbox"/> Cup		<input type="checkbox"/> Add or Remove SBI <input type="checkbox"/> Add/Change/Correct insured's Authorized Rep. <input type="checkbox"/> Change/correct insured's address <input type="checkbox"/> Correct insured's identification number <input type="checkbox"/> Correct spelling of insured's name <input type="checkbox"/> Correct SBI's identification Number <input type="checkbox"/> Correct the spelling of SBI's Name		(Check One) <input type="checkbox"/> Insured's Request Death, <input type="checkbox"/> Incompetence, or Dissolution (Explain In Remarks) <input type="checkbox"/> Mutual Consent <input type="checkbox"/> Other		
IRS Accounting Method: <input type="radio"/> Cash <input type="radio"/> Accrual			<i>If more than one option is selected, the option that results in the highest revenue amount will be considered elected.</i>						
Is Applicant a Vertically Integrated Producer? <input type="checkbox"/> Yes <input type="checkbox"/> No									
<input type="checkbox"/> Yes Check "Yes" if you want to exclude FCIC Reinsured policies from becoming primary insurance. If excluded, there will be no liability adjustment for premium purposes on the WFRP policy and claims may be affected.									
Remarks:									

* Plan of Insurance cannot be changed using a policy change between different plans of insurance for differing Basic Provisions (i.e. RP to ARPI).

Application/Transfer/Change/Cancel Form

Insured's Name:		Agency Code:		Policy#																																				
		Agency Name:																																						
<p>Conditions of Acceptance: This application is accepted and insurance attaches in accordance with the policy unless:</p> <p>(1) The Federal Crop Insurance Corporation determines that, in accordance with the regulations, the risk is excessive; (2) any material fact is omitted, concealed or misrepresented in this application or in the submission of this application; (3) you have failed to provide complete and accurate information required by this application; or (4) the answer to any of the following questions is "yes". An answer of "yes" to these questions does not automatically result in rejection of the application. For example, if you answer "yes" to question (a) but your debt was discharged in bankruptcy; the application would not be rejected.</p> <div><div>YesNo</div><div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div><div>(a) Are you now indebted and the debt is delinquent for insurance coverage under the Federal Crop Insurance Act?</div><div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div><div>(b) Have you in the last five years been convicted under federal or state law of planting, cultivating, growing, producing, harvesting, or storing a controlled substance?</div><div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div><div>(c) Have you ever had insurance coverage under the authority of the Federal Crop Insurance Act terminated for violation of the terms of the contract or regulations, or for failure to pay your delinquent debt?</div><div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div><div>(d) Are you disqualified or debarred under the Federal Crop insurance Act, the regulations of the Federal Crop Insurance Corporation, or the United States Department of Agriculture?</div><div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div><div>(e) Have you ever entered into an agreement with the Federal Crop Insurance Corporation or with the Department of Justice that you would refrain from participating in programs under the authority of the Federal Crop Insurance Act and that agreement is still effective?</div><div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div><div>(f) Do you have like Insurance on any of the above crop(s)?</div><div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div></div>				<p>SBI Information: List all person(s) with a substantial beneficial interest in you as defined in the applicable policy provisions (including landlords or tenants insured under the applicant). If none, state "NONE." (For additional space, attach SSN/EIN Form)</p> <table><thead><tr><th>Name</th><th>Address</th><th>ID# / Phone #</th><th>ID Type</th><th>Person Type</th></tr></thead><tbody><tr><td></td><td></td><td></td><td><input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN</td><td></td></tr><tr><td></td><td></td><td></td><td><input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN</td><td></td></tr><tr><td></td><td></td><td></td><td><input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN</td><td></td></tr><tr><td></td><td></td><td></td><td><input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN</td><td></td></tr><tr><td></td><td></td><td></td><td><input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN</td><td></td></tr><tr><td></td><td></td><td></td><td><input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN</td><td></td></tr></tbody></table>		Name	Address	ID# / Phone #	ID Type	Person Type				<input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN					<input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN					<input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN					<input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN					<input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN					<input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN	
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<p>I understand that if coverage for any crop is currently terminated or would have subsequently terminated for indebtedness had this application been filed after the termination date, no coverage can be provided and I am ineligible for any benefits under the Federal Crop Insurance Act until the cause for termination is corrected. We will notify you of rejection by depositing notification in the United States mail, postage paid, to the applicant's address. Unless rejected or the Sales Closing Date has passed at the time you signed this application, insurance will be in effect for the policy year specified and will continue for each succeeding policy year, unless otherwise specified in the policy, until canceled, terminated or voided. No term or condition of the contract shall be waived or changed unless such waiver or change is expressly allowed by the contract and is in writing.</p>																																								
<p>Authority to sign crop insurance documents on behalf of the insured</p> <p>"I grant the person(s) listed below the authority to sign any and all crop insurance documents on my behalf. I understand that by authorizing such persons to sign documents on my behalf I am legally bound by all terms and conditions of such documents and of the crop insurance contract. I also understand that granting the following person(s) the authority to sign on my behalf does not obligate that person(s) to the terms and conditions of my crop insurance contract. I further understand that this authorization may be revoked by me at any time upon written notice, signed and delivered to my Approved Insurance Provider."</p>																																								
Name		Address		Telephone	Grant																																			
					<input type="checkbox"/>																																			
					<input type="checkbox"/>																																			
<p>Cancellation & Transfer</p>																																								
Name of Previous AIP (if any)				Policy # under Previous AIP																																				
<p>I hereby authorized and direct the above Ceding Approved Insurance Provider to furnish any information relative to my insurance policy to the Assuming Approved Insurance Provider listed below. I understand that if coverage for any crop(s) is now terminated or would have subsequently terminated for indebtedness had this transfer not occurred, no coverage can be provided by the NAU Country.</p>																																								
<p>I hereby request cancellation of my WFRP insurance policy shown on this cancellation. I understand that if this form is not executed on or before the cancellation date listed, the cancellation date of my WFRP insurance will not become effective until the following policy year.</p>																																								
<p>Part I</p> <p>I hereby request cancellation of my WFRP policy with _____ for the (Policy year of policy cancelled and transferred) because I have applied for insurance with another Approved Insurance Provider. I understand that if this form is not executed on or before the established cancellation date, the cancellation of my WFRP insurance will not become effective until the following policy year.</p>			<p>Part II</p> <p>By submission of this form, we agree to provide WFRP insurance to this applicant for the policy year specified above unless this form is not executed on or before the established cancellation date, in which case WFRP insurance will be provided for the following policy year.</p>																																					
Name of Assuming Agent: Address, City, St., Zip:				Date of acceptance by Assuming Approved Insurance Provider:																																				
AIP Representative Printed Name and Signature: Printed Name:				Assuming AIP & Policy Issuing Company Code:																																				
Signature:																																								

Applicant/Insured Information								Effective Policy Year:				Agency Information				Policy Number:			
Name: _____ ID #: _____ Street or Mailing Address: _____ ID # Type: _____ City, State, Zip: _____ Person Type: _____ Phone #: _____ Spouse's Name: _____ Spouse's ID #: _____ Authorized Representative: _____ Is applicant at least 18 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No								State: _____ County(ies): _____				Agency Code: _____ Agent Name: _____ Agency Name: _____ Address: _____ City, State, Zip: _____ Phone #: _____ E-Mail: _____				NAU Country Insurance Underwriter: _____			
FOR Line #		Commodity Name			Commodity Code		Rate Code		FOR Line #		Commodity Name			Commodity Code		Rate Code			
U of M			Practice		Type/ Variety			U of M			Practice		Type/ Variety						
Year Produced	Total Production	Acres	Average Yield	Net Revenue	Average Revenue	Producer's Share	100% Share Equivalent Rev.	Year Produced	Total Production	Acres	Average Yield	Net Revenue	Average Revenue	Producer's Share	100% Share Equivalent Rev.				
Record Type: <input type="checkbox"/> Farm Stored -measured by insured/AIP <input type="checkbox"/> Pick/Daily Sales Record <input type="checkbox"/> Yield Monitoring System <input type="checkbox"/> Livestock Feeding Records <input type="checkbox"/> Third-Party Record <input type="checkbox"/> Other					Replacement Yield Expected Yield Expected Value			Record Type: <input type="checkbox"/> Farm Stored -measured by insured/AIP <input type="checkbox"/> Pick/Daily Sales Record <input type="checkbox"/> Yield Monitoring System <input type="checkbox"/> Livestock Feeding Records <input type="checkbox"/> Third-Party Record <input type="checkbox"/> Other					Replacement Yield Expected Yield Expected Value						
Hard copy records must be provided, if requested.								Hard copy records must be provided, if requested.											
Remarks:								Remarks:											

Expected Value and Yield Document Certification Worksheet

Applicant/Insured Information		Agency Information	Policy Number:
Name: _____ ID #: _____ Street or Mailing Address: _____ ID # Type: _____ City, State, Zip: _____ Person Type: _____ Phone #: _____ Spouse's Name: _____ Spouse's ID #: _____ Authorized Representative: _____ Is applicant at least 18 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Year: State: _____ County(ies): _____	Agency Code: _____ Agent Name: _____ Agency Name: _____ Address: _____ City, State, Zip: _____ Phone #: _____ E-Mail: _____	NAU Country Insurance Underwriter:

Part 2: Commodity Information

5. Commodity	6. Commodity Code	7. Rate Code	8. Practice	9. Type	10. Variety	11. Unit of Measure	12. Expected Yield	13. Source	14. Expected Value	15. Source

Part 3: Combined Direct Marketing Commodity or Micro Farm Information

16. Name of Market: _____				
17. Years Produced ¹	18. Total Planted Acres or Other Unit of Measure	19. Revenue	Exclude ²	22. Remarks:
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
20. Average				
21. Expected Value per Acre				

¹Combined Direct Market = 3-year database. Micro Farm = 5-year database.

² For Micro Farm, you may exclude one year if five years are provided.

Applicant/Insured Information
Name: ID #:
Street or Mailing Address: ID # Type:
City, State, Zip:
Person Type: Phone #:
Spouse's Name: Spouse's ID #:
Authorized Representative:
Is applicant at least 18 years old? Yes No

Policy Year:
State:
County(ies):

Agency Information
Agency Code:
Agent Name:
Agency Name:
Address:
City, State, Zip:
Phone #:
E-Mail:

Policy Number:
NAU Country Insurance
Underwriter:

4a. Did the county where the majority of revenue is expected to be earned change within the policy year? If yes, update County above.
5. Other Insurance: If Yes, enter information in 5a, 5b, and 5c below

Table with 20 columns: 6. Commodity Name, 7. Commodity Code, 8. Rate Code, 9. Method of Establishment, 10. Yield, Unit of Measure, 11. Expected Value, 12. Expected Revenue (10x11), 13A. Intended Quantity, 13B. Cost/Basis and/or Value, 13C. Share, 13D. Int. Percent Produced to Sell, 13E. Total Expected Revenue, 14A. Actual Quantity, 14B. Actual Cost/Basis and/or Value, 14C. Share, 14D. Revised Percent Produced to Sell, 14E. Total Expected Revenue, 15A. Final Production, 15B. Final Revenue. Includes summary rows 16-21.

24. Integrated/Post-Production Operations: Yes No
25. MPCJ Liability:
23. Narrative, Expected Values, and Report of Changes:

New Application Packet - Whole Farm Revenue Protection

Allowable Revenue Worksheet



1. Producer Information		4. Tax Year:	2. Policy No:	
Name: _____ Address: _____ City, State, Zip: _____ Phone #: _____ Person Type: _____		3. State: _____ County: _____	NAU Country Insurance Company 7333 Sunwood Drive Ramsey, MN 55303 763.427.3770 5. Adjustment Codes: A = Schedule F income specifically excluded B = Cost of post-production operations C = Co-op distributions not directly related G = Net gain from commodity hedges H = Not directly related to production I = Other	
6. Schedule F Part I (cash) or III Revenue (accrual)	7. Schedule F Line Number	8. Amount on Schedule F	9. Revenue Adjustment Amount and Code	10. Allowable Revenue Per Item
a. Sales of animals and other resale items, less the cost or other basis of such items	1c or 37			
b. Sales of livestock, produce, grains, and other products you raised	2 or 37			
c. Cooperative distributions	3b or 38b			
d. Agricultural program payments	4b or 39b			
e. Commodity Credit Corporation (CCC) loans reported under election	5a or 40a			
f. CCC loans forfeited	5c or 40c			
g. Crop insurance proceeds and federal crop disaster payments	6b or 41			
h. Custom hire (machine work) income	7 or 42			
i. Other income, including federal and state gasoline or fuel tax credit or refund:				
Federal and state gasoline or fuel tax credit or refund	8 or 43			
Income from bartering				
Payments from buyers of commodities for bypassed acreage				
Payments from marketing orders				
Other commodity income not reported elsewhere				
11. Total Schedule F Part I or III Revenue				
			12. Allowable Revenue for Tax Year	

See final page for RMA required statements

New Application Packet - Whole Farm Revenue Protection

Allowable Revenue Worksheet



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New Application Packet - Whole Farm Revenue Protection

Allowable Revenue Worksheet



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See final page for RMA required statements

New Application Packet - Whole Farm Revenue Protection

Allowable Revenue Worksheet



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11. Total Schedule F Part I or III Revenue				
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See final page for RMA required statements

New Application Packet - Whole Farm Revenue Protection

Allowable Revenue Worksheet



1. Producer Information		4. Tax Year:	2. Policy No:	
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Payments from marketing orders				
Other commodity income not reported elsewhere				
11. Total Schedule F Part I or III Revenue				
			12. Allowable Revenue for Tax Year	

See final page for RMA required statements

New Application Packet - Whole Farm Revenue Protection
Whole - Farm History Report



1. Producer Information:	3. Policy Year:	2. Agency Information:	Policy No:
ID #: _____ ID type: _____ Name: _____ Address: _____ City, State, Zip: _____ Phone #: _____ Email: _____ Person Type: _____	5. State: _____ County: _____	Code: _____ Agency Name: _____ Address: _____ City, State, Zip: _____ Phone #: _____ Email: _____	4. IRS Accounting Method: <input type="radio"/> Cash <input type="radio"/> Accrual NAU Country Insurance Company 7333 Sunwood Drive Ramsey, MN 55303 763.427.3770

6. Tax Year	7. Allowable Revenue	8. Indexed Revenue
<input type="checkbox"/> 3 years		
<input type="checkbox"/> 4 years		
10. Total	a. _____	b. _____
11. Simple Average	a. _____	b. _____
12. Revenue Substitution	a. _____	b. _____
13. Revenue Exclusion	a. _____	b. _____
14. Revenue Cup (90% of last year's Approved Revenue) Enter Last year's Approved Revenue: _____	x 0.9 = _____	
15. Expanded Operation <input type="checkbox"/> Yes		OC Expanded Revenue: (Current and/or Lag Year)
For expansions not due solely to organic (OC) sources, enter the percent value here (<= 35%).	Percent: _____	For expansions due solely to certified organic (OC) sources, enter the amount of revenue for the certified organic expansion above.
16. Average	a. _____	b. _____
17. Indexed Average <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Must select Yes or No</i>	18. Insurance Options <input type="checkbox"/> Substitution <input type="checkbox"/> Exclusion <input type="checkbox"/> Cup <i>If more than one option is selected, the option that results in the highest revenue amount will be considered elected.</i>	
19. Whole-Farm Historic Average (Greater of item 14 (if elected), 15, 16a, or 16b)		

I certify that to the best of my knowledge and belief all of the information on this form is correct. I understand that information on this form may be reviewed and audited. I understand that inaccurate information or my failure to retain or provide, upon request, records supporting the information on this form may result in denial of coverage, cancellation of my policy, ineligibility for indemnity, or recalculation of insured revenue. I also understand that failure to report completely and accurately may result in sanctions under my policy, including but not limited to voidance of the policy, and in criminal or civil penalties (18 U.S.C. §1006 and §1014; 7 U.S.C §1506; 31 U.S.C. §3729, §3730 and any other applicable federal statutes).

Applicant/Insured Printed Name and Signature	Date
Printed Name: _____	
Signature: _____	
AIP Representative Printed Name and Signature	Date
Printed Name: _____	
Signature: _____	

Applicant/Insured Information			Agency Information	Policy Number:
Name: _____ ID #: _____		Policy Year:	Agency Code: _____	NAU Country Insurance
Street or Mailing Address: _____ ID # Type: _____		State:	Agent Name: _____	
City, State, Zip: _____			Agency Name: _____	
Person Type: _____ Phone #: _____		County(ies):	Address: _____	
Spouse's Name: _____ Spouse's ID #: _____			City, State, Zip: _____	Underwriter:
Authorized Representative: _____			Phone #: _____	
Is applicant at least 18 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No			E-Mail: _____	

PART 2. ACCOUNTS RECEIVABLE

5. Commodity Name	6. Name and Address of Buyer	7. Beginning Amount (dollars)	8. Ending Amount (dollars)	9. Balance (8-7)
		10. Total Accounts Receivable Adjustment to Claim (dollars)		

1. Producer Information
3. Policy Year:
4. Agency Information
2. Policy No:
Name:
Address:
City, State, Zip:
Phone #:
Code:
Agency Name:
Address:
City, State, Zip:
Phone #:
QBE/NAU Office

PART 2 - BREEDING LIVESTOCK ONLY

Table with 3 main columns: Type of Animals or Commodities, Section A - Beginning Inventory First Day of the Insurance Period, and Section B - Ending Inventory Last Day of the Insurance Period. Includes rows for 5. Type/Category, 6. Number, and 7. Number.

PART 3 - MARKET ANIMALS OR NURSERY

Table with 3 main columns: Type of Animals or Commodities, Section A - Beginning Inventory First Day of the Insurance Period, and Section B - Ending Inventory Last Day of the Insurance Period. Includes rows for 8. Type/Category, 9. Number, 10. Average Weight or Container Size, 11. Average Value, 12. Average Value/Unit (10 x 11), 13. Total \$ Value (9 x 12), 14. Actual Cost (Claims Only), 15. Net Value (Claims Only), 16. Number, 17. Average Weight or Container Size, 18. Average Value, 19. Average Value/Unit (17 x 18), 20. Total \$ Value (16 x 19), 21. Cost or Basis, and 22. Net \$ Value (20-21).

23. Total Beginning Value:
24. Total Ending Value:

PART 4 - INVENTORY ADJUSTMENT (to be completed ONLY if a claim is filed)

25. Adjustment: (Amount in item 24) - (Amount in Item 23) = Inventory Adjustment. Enter result, (+) or (-), in item 28 on the Claim for Indemnity Form.

See final page for RMA required statements

Applicant/Insured Information
Policy Year:
Agency Information
Policy Number:
Name: ID #:
Street or Mailing Address: ID # Type:
City, State, Zip:
Person Type: Phone #:
Spouse's Name: Spouse's ID #:
Authorized Representative:
Is applicant at least 18 years old? Yes No
Agency Code:
Agent Name:
Agency Name:
Address:
City, State, Zip:
Phone #:
E-Mail:
NAU Country Insurance
Underwriter:

The applicant/insured must be the same person and person type as the person designated on the United States Income Tax form(s).

IRS Accounting Method: Cash Accrual

INVENTORIED COMMODITIES

	Part 2: Beginning Inventory First day of the insurance period		Part 3: Beginning Inventory Value end of insurance period			Part 4: Ending Inventory Last day of the insurance period				
6. Commodity Name	7. Location(s)	8. Beginning Inventory	9. Value	10. Cost or Basis	11. Value Received (8 x 9)	12. Location(s)	13. Ending Inventory	14. Average Value	15. Cost or Basis	16. Net Value (13 x 14) -15
			17. Total Beginning Value:					18. Total Ending Value:		

PART 5 - INVENTORY ADJUSTMENT (To be completed ONLY if a claim is filed)

19. Adjustment:
Item 18 Amount: - Item 17 Amount: = Inventory Adjustment.
Enter this amount, (+) or (-) in item 26 on the Claim for Indemnity Form.

Insured's Name:		Agency Code:		Policy#	
		Agency Name:			
<p>COLLECTION OF INFORMATION AND DATA (PRIVACY ACT) STATEMENT - Agents, Loss Adjusters and Policyholders</p> <p>The following statements are made in accordance with the Privacy Act of 1974 (5 U.S.C. 552a): The Risk Management Agency (RMA) is authorized by the Federal Crop Insurance Act (7 U.S.C. 1501-1524) or other Acts, and the regulations promulgated thereunder, to solicit the information requested on documents established by RMA or by approved insurance providers (AIPs) that have been approved by the Federal Crop Insurance Corporation (FCIC) to deliver Federal crop insurance. The information is necessary for AIPs and RMA to operate the Federal crop insurance program, determine program eligibility, conduct statistical analysis, and ensure program integrity. Information provided herein may be furnished to other Federal, State, or local agencies, as required or permitted by law, law enforcement agencies, courts or adjudicative bodies, foreign agencies, magistrate, administrative tribunal, AIP's contractors and cooperators, Comprehensive Information Management System (CIMS), congressional offices, or entities under contract with RMA. For insurance agents, certain information may also be disclosed to the public to assist interested individuals in locating agents in a particular area. Disclosure of the information requested is voluntary. However, failure to correctly report the requested information may result in the rejection of this document by the AIP or RMA in accordance with the Standard Reinsurance Agreement between the AIP and FCIC, Federal regulations, or RMA-approved procedures and the denial of program eligibility or benefits derived therefrom. Also, failure to provide true and correct information may result in civil suit or criminal prosecution and the assessment of penalties or pursuit of other remedies.</p>					
<p>NON-DISCRIMINATION POLICY STATEMENT</p> <p>In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident. Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at www.usda.gov/about-usda/general-information/staff-offices/office-assistant-secretary-civil-rights/how-file-program-discrimination-complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 6329992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. USDA is an equal opportunity provider, employer, and lender.</p>					
<p>Insured Anti-Rebating Statement:</p> <p>"I certify, for the policy year indicated, that I have not directly or indirectly received, accepted, or been paid, offered, promised, or given any benefit, including money, goods, or services for which payment is usually made, rebate, discount, abatement, credit, or reduction of premium, or any other valuable consideration, as an inducement to procure insurance or in exchange for purchasing this insurance policy after it has been procured. I understand that this prohibition does not include payment of administrative fees, performance based discounts, and any other payment approved by FCIC that are authorized under sections 508(a)(9)(B) and 508(d)(3) of the Federal Crop Insurance Act (Act) (7 U.S.C. §§ 1508(a)(9)(B) and 1508(d)(3)). I understand that a false certification or failure to completely and accurately report any information on this form may subject me, and any person with a substantial beneficial interest in me, to sanctions, including but not limited, to criminal and civil penalties and administrative sanctions in accordance with section 515(h) of the Act (7 U.S.C. § 1515(h)) and all other applicable federal statutes."</p>			<p>Agent Anti -Rebating Statement:</p> <p>"I certify, for the policy year indicated, that I have neither offered nor promised, directly or indirectly, any benefit, including money, goods, or services for which payment is usually made, rebate, discount, credit, reduction of premium, or any other valuable consideration to this person either as an inducement to procure insurance or in exchange for obtaining insurance after it has been procured. I understand that this prohibition does not include payment of administrative fees, performance based discounts, and any other payment approved by FCIC that are authorized under sections 508(a)(9)(B) and 508(d)(3) of the Federal Crop Insurance Act (Act) (7 U.S.C. §§ 1508(a)(9)(B) and 1508(d)(3)). I understand that a false certification or failure to completely and accurately report any violation may subject me, and all agencies/companies I represent, to sanctions, including but not limited, to criminal and civil penalties and administrative sanctions in accordance with section 515(h) of the Act (7 USC § 1515(h)) and all other applicable federal statutes."</p>		
<p>I certify that to the best of my knowledge and belief all of the information on this form is correct. I understand that changes to intended commodities grown will result in changes to the insured revenue, premium rate, and indemnity. I understand the information on this form may be reviewed and audited. I understand that inaccurate information or my failure to retain or provide, upon request, records supporting the information on this form may result in denial of coverage, cancellation of my policy, ineligibility for indemnity, or recalculation of approved revenue. I also understand that failure to report completely and accurately may result in sanctions under my policy, including but not limited to voidance of the policy, and in criminal or civil penalties (18 U.S.C. §1006 and §1014; 7 U.S.C. §1506; 31 U.S.C. §3729, §3730 and any other applicable federal statutes).</p>					
<p>Application/Transfer/Policy Change Statement:</p> <p>I understand that:</p> <p>(a) my approved revenue for the five years in the whole-farm history period and my expected revenue for the current year may be adjusted as required under the terms of the WFRP policy, and that such adjustments may affect the amount of insured revenue and any indemnity;</p> <p>(b) no insurance will be provided unless this application and all required forms are completed and filed on or before the SCD for the policy year in which I am requesting WFRP coverage; and</p> <p>(c) although insurance under this application is continuous from year to year, policy terms, premium rates, and the amount of revenue insured may change from year to year.</p>					
<p>NATIVE SOD STATEMENT</p> <p>I <input type="checkbox"/> HAVE or <input type="checkbox"/> HAVE NOT broken native sod after February 7, 2014. This statement only applies to counties in Iowa, Minnesota, Montana, Nebraska, North Dakota, and South Dakota. I understand that if I till native sod acreage, I will be assessed a reduction in yield guarantee and premium subsidy, these reductions apply in the crop year that my total native sod acreage tilled exceeds 5 acres in the county (cumulated across crops and crop years), and these reduction in benefits may be retroactively applied within a crop year. For any native sod acreage broken after December 20, 2018, identify the year it was broken separately for each parcel: _____</p>					
Applicant/Insured Printed Name and Signature		Date	Agent Printed Name and Signature		Code Date
Printed Name:			Printed Name:		
Signature:			Signature:		
AIP Authorized Representative Printed Name and Signature					Date
Printed Name:					Signature: