



Policy Change Form

1/16/2026

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American Agri-Business Insurance Co. (601)

Name:		Agency: Walock - Johnson Insurance, Inc.	
Street and/or Mailing Address: _____	Policy #: _____	Agent: PO BOX 513 LISBON, ND 58054-0513	Agency Code: 381570
City, State, Zip: _____	Identification: _____		
Phone: _____	Identification Type: SSN <input type="checkbox"/> EIN <input type="checkbox"/> RAN <input type="checkbox"/>	Business: (701) 683-5253	Business Fax: (888) 436-5536
Entity Type: _____			
Email: _____		Email: _____	
Authorized Rep. / Power of Attorney: _____		Loss Payable to Me and: _____	

I request insurance coverage for my share of the Category B crops (except forage) specified below with a designated county in all added counties within the state/nation where the crops are insurable.

☐ Yes

☐ No

Check Appropriate Box	Effective Crop Year	State	County	Name of Crop	Insurance Plan	Coverage Level Elect LP	% of Price Elect, Projected Price, Amt of Ins, or Prot Fact	Designated County	Type	Practice	Options, Elections, or Endorsements
<input type="checkbox"/> Change <input type="checkbox"/> Cancel						IRR - NIRR -					
<input type="checkbox"/> Change <input type="checkbox"/> Cancel						IRR - NIRR -					
<input type="checkbox"/> Change <input type="checkbox"/> Cancel						IRR - NIRR -					
<input type="checkbox"/> Change <input type="checkbox"/> Cancel						IRR - NIRR -					
<input type="checkbox"/> Change <input type="checkbox"/> Cancel						IRR - NIRR -					



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Reasons for Cancellation (check one & explain in Remarks)	Other Changes (as indicated above)	<input type="checkbox"/> Correct SBI's identification number Previous ID number: _____
<input type="checkbox"/> Insured's Request	<input type="checkbox"/> Add or remove SBI	<input type="checkbox"/> Correct spelling of SBI's name
<input type="checkbox"/> Death, Incompetence, or Dissolution	<input type="checkbox"/> Change/correct insured's address	<input type="checkbox"/> Add/change/correct insured's authorized representative
<input type="checkbox"/> Mutual Consent	<input type="checkbox"/> Correct insured's identification number Previous ID number: _____	<input type="checkbox"/> Add or remove "Added County" election
<input type="checkbox"/> Other	<input type="checkbox"/> Correct spelling of insured's name	<input type="checkbox"/> Correct entity type
		<input type="checkbox"/> Other (explain in Remarks)

For individual entities, if applicable, indicate spouse's name and SSN. For other insured entities, List all persons or entities with a substantial beneficial interest in you as defined in the applicable policy provisions (include landlords or tenants insured under the applicant). If none, state NONE.

Entity Type	Name	Address	Phone	Type of Identification	Identification Number

Remarks

Add authority for designated person(s) to sign crop insurance documents on behalf of the insured.
☐ 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.

☐ **Please revoke the authority to sign crop insurance documents on behalf of the insured for the following designated person(s)**

CERTIFICATION STATEMENT: I certify that to the best of my knowledge and belief all of the information on this form is correct. 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).

(Insured Printed Name)

(Insured Signature)

(Date/Time)

(Agent Printed Name)

(Agent Signature)

(Date/Time)

381570
(Agency Code)



COLLECTION OF INFORMATION AND DATA (PRIVACY ACT) STATEMENT - Agents, Loss Adjusters and Policyholders
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, AIPs 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 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.

NONDISCRIMINATION STATEMENT

Non-Discrimination Policy

The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

To File a Program Complaint

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter by mail to the U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Persons with Disabilities

Individuals who are deaf, hard of hearing or have speech disabilities and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish).

Persons with disabilities, who wish to file a program complaint, please see information above on how to contact the Department by mail directly or by email. If you require alternative means of communication for program information (e.g., Braille, large print, audiotape, etc.) please contact USDA's TARGET Center at (202) 720-2600 (voice and TDD).

