



# ASSIGNMENT OF INDEMNITY

American Omni Crop, LLC  
1510 29th Ave S  
Moorhead, MN 56560

Tel: (218) 284-5818  
Fax: (218) 284-5820

_____ Insured's Name  _____ Insured's Authorized Representative  _____ Street or Mailing Address  _____ City, State Zip	Approved Insurance Provider's Name & Address:	Policy Number:
		Effective Crop Year:
		Crop Name and County Name:

The insured

assigns to \_\_\_\_\_  
(Name of Creditor)

of \_\_\_\_\_  
(Mailing Address)

\_\_\_\_\_  
(City, State and Zip Code)

the right and interest of any indemnity payment(s) which may be payable to the insured under the insurance policy for the county/commodity(ies) shown above.

### CONDITIONS

1. This assignment will be binding upon the person(s) who succeed the Insured's interest in the insurance policy.
2. Indemnity payments made under the insurance policy will be subject to a deduction for any indebtedness due this Approved Insurance Provider by the Insured.
3. This assignment will not grant the Creditor any greater rights than originally held by the Insured.
4. The Creditor's interest will be recognized upon Approved Insurance Provider's approval of this assignment and the Creditor will have the right to submit the loss notices and other forms as required by the Policy.
5. The Approved Insurance Provider will determine the person(s) entitled to any indemnity payments(s) and the payment(s) will be by joint check.
6. If the assignment is not cancelled according to item 7 below, the assignment will cease at the end of the effective crop year.
7. Cancellation of this assignment prior to and during the crop year stated above will be accepted by the Approved Insurance Provider only upon notification in writing by the above identified Creditor(s).

It is understood and agreed that this assignment will be subject to the terms and conditions of the insurance policy.

\_\_\_\_\_  
Insured's Signature Date

\_\_\_\_\_  
Creditor's Signature Date

\_\_\_\_\_  
Witness' Signature Date

\_\_\_\_\_  
Witness' Signature Date

The Approved Insurance Provider hereby approves the foregoing assignment.

This assignment was filed with the Approved Insurance Provider on	
_____	a.m.
_____	p.m.
(Month, Day Year) at _____	

\_\_\_\_\_  
Approved Insurance Provider Representative's Signature Date

**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, 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.

**NONDISCRIMINATION STATEMENT**

The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, age, disability, and where applicable, sex, marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, reprisal, or because all or a part of an individual's income is derived from any public assistance program. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET center at (202) 720-2600 (voice and TDD).

To file a complaint of discrimination, write to: USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6382 (TDD). USDA is an equal opportunity provider and employer.

**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).