

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION, BUREAU OF INSURANCE

**QUARTERLY UPDATE TO THE CERTIFICATE OF ASSUMING INSURER
FOR THE QUARTER ENDED _____**

A PROPERLY EXECUTED FORM SHOULD BE FILED FOR EACH QUARTER BY ACCREDITED, SUBSTANTIALLY SIMILAR AND TRUSTED REINSURERS OPERATING IN VIRGINIA.

PART I: IDENTIFYING DATA

State of Domicile or Entry NAIC Co. Code

Name of Assuming Insurer

PART II: AFFIDAVIT AND SUBMISSIONS

Has the Assuming Insurer begun assuming business from an insurer domiciled in Virginia in the past quarter?

If yes, list the names of these insurers below _____ Yes _____ No

If yes, list the names of the these insurers below.

Name of Insurer

Date Began:

Has the Assuming Insurer ceased assuming business from an insurer domiciled in Virginia in the past quarter?

If yes, list the names of these insurers below.

Name of Insurer

Date Ended:

On behalf of _____
("Assuming Insurer")

(Name of Officer) , (Title)

Dated and signed this _____ day of _____, 20____ at _____.

being duly sworn according to law, deposes and says that the answers to the questions and the declarations contained in this certificate are true and correct.

(Signature of Officer) _____ (Title) _____