

**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 TRUSTEED 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?
_____ 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?
_____ Yes _____ No

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)