

APPENDIX A

**RECISSION REPORTING FORM FOR  
LONG-TERM CARE POLICIES  
FOR THE STATE OF \_\_\_\_\_  
FOR THE REPORTING YEAR 20[ ]**

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Due March 1 annually

**Instructions:**

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy/Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name/Title (please type)

\_\_\_\_\_  
Date