RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES
FOR THE STATE OF MISSOURI
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 (1) form per rescission.

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

Detailed reason for rescission:
_____
_____

_____
_____

_____
_____

_____
_____

_____
_____
_____

Signature

_____

Name and Title (please type)

_____

Date

LTC-A
(Rev 11/15/2007)