

**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)