RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES
FOR KENTUCKY
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 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