[Insurance Company Name and Address]

Long-term Care Partnership Insurance (LTCPI) Program

Statement of Benefits Paid

1. Name of Insured _____
2. [Insured's Social Security Number or Date of Birth]
3. Effective Date of LTCPI policy/certificate:_____
4. Name of State where LTCPI policy or certificate was issued: _____
5. Issue age of insured at the time the coverage was issued: _____
6. The policy/certificate was issued: □ With □ Without Inflation Coverage.
7. The inflation coverage is □ Simple inflation □ Compound inflation □ None
8. The inflation coverage is currently in effect: □ Yes □ No
9. The policy is intended to meet standards of a tax-qualified long-term care insurance policy?
   □Yes □ No
10. Benefits under this LTCPI policy/certificate are paid on a per diem basis.
    □ Yes (If "yes" please enter amount $_____ per day) □ No
11. Daily benefit used: □ Nursing home □Assisted Living Facility □Home Health
12. The total dollar amount of LTCPI insurance benefits paid is $_____.
(**Note**: The indicated amount does not include any payments for cash surrender, return of premium death benefits, or waiver of premium, and if joint coverage, the amount is for the indicated insured only)
13. The total dollar amount of insurance benefits remaining available under the LTCPI policy is $_____.
14. The name, phone number, and email address of a contact person regarding this form:

Name: _____

Phone Number: _____

Email Address: _____

I hereby certify that the above information is true and accurate at the time of this certification.

_____ Date: _____

Signature of Authorized Insurer Representative

_____

Title of Authorized Insurer Representative