OFFICE OF INSURANCE REGULATION
Market Investigations

Appendix A

Rescission Reporting Form For
Long-Term Care Policies
For the State of Florida
For the Reporting Year 20__

Insurer Name:	
Address	No., Street, unit #:
	City, State, Zip code:
Phone Number: ( ) -	

Due: March 1st - 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.

Mail to: Florida Office of Insurance Regulation
Market Investigations
200 E. Gaines Street
Tallahassee, FL 32399-4210

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