



**OFFICE OF INSURANCE REGULATION**  
***Life & Health Product Review***

**APPROVED LONG TERM CARE PARTNERSHIP PROGRAM POLICY SUMMARY**

1. Name of insured \_\_\_\_\_
2. Policy/certificate number \_\_\_\_\_
3. Effective date of coverage \_\_\_\_\_
4. The policy/certificate was issued in the state of \_\_\_\_\_
5. Issue age of the 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 on the coverage  Yes  No  
if no, the date inflation coverage ceased \_\_\_\_\_
9. The policy is intended to meet the standards of a tax qualified long-term care policy  Yes  No
10. The cumulative dollar amount of insurance benefits paid \$\_\_\_\_\_ (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)
11. The total dollar amount of insurance benefits remaining available under the policy \$\_\_\_\_\_
12. As of date for which this form was completed \_\_\_\_\_
13. The name, phone number and email address of the person completing this form

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Email Address

I hereby certify that the above information is true and accurate and that the coverage meets partnership status in Florida at the time of this certification.

\_\_\_\_\_  
Signature

Date: \_\_\_\_\_