OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES.
REPORTING YEAR _____
STATE OF Washington
Due March 1st annually.

Company Name:
Address:
Phone Number:
NAIC Number:

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 the report. Please furnish one form per rescission.

Policy Form #	Policy &/or Certificate #	Name of Insured	Date of Policy Issuance	Date(s) Claim(s) Submitted	Date of Rescission

Detailed reason for rescission: _____

_____

_____

_____
Signature

_____
Print Name and Title

_____
Date