WEST VIRGINIA Department of Health & Human Resources

LONG-TERM-CARE INSURANCE PARTNERSHIP (LTCIP) POLICY VERIFICATION

This form is to be given to the applicant/recipient for the purpose of obtaining verification regarding their LTCIP Policy.

1. Name of Insured: _____

2. Issuing insurance company and policy/certificate number: _____

3. Issuing state of policy/certificate: _____

4. Policy/certificate issuance date: _____

5. If the LTCIP policy was issued in or originated in another state prior to being exchanged for a WV issue policy, provide the date of the other state's LTCIP State Plan Amendment that addresses LTCIP: _____

6. I certify that this LTC policy meets the IRS and NAIC Model Regulations and Model Act in accordance with Section 1817(b)(5)(A) of the Social Security Act: [ ] Yes [ ] No

7. a. If the LTCIP policy is issued in WV, provide the total dollar amount of Long-Term-Care Partnership insurance benefits paid on the applicant/recipient's behalf as of July 1, 2010:
   $ _____
   b. If the LTCIP policy was issued in or originated in another state prior to being exchanged for a WV issued policy, provide the total dollar amount of Long-Term-Care Partnership insurance benefits paid on the applicant/ recipients behalf since the date listed in #5: $ _____
   (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.)

8. Provide the total dollar amount of insurance benefits remaining available under the policy:
   $ _____

9. Name, phone number and e-mail address of the person completing this form:

   Name and Title _____

   Phone Number _____

   E-mail Address _____

I hereby certify that the above information is true and accurate.

Signature/Date _____