**Section 2012.EXHIBIT D Rescission Reporting Format**

RESCISSION REPORTING FORMS FOR

LONG-TERM CARE POLICIES

FOR THE STATE OF ILLINOIS

FOR THE REPORTING YEAR 20[ ]

|  |  |
| --- | --- |
| Company Name: |  |
| Address: |  |
|  |  |
| Phone Number: |  |

Due: March 1 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.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| PolicyForm # | Policy andCertificate # | Name of Insured | Date of PolicyIssuance | Date/sClaim/sSubmitted | Date ofRescission |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Detailed reason for rescission:

|  |
| --- |
|  |
|  |
|  |
|  |

|  |
| --- |
| Signature |
| Name and Title (please type) |
| Date |

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)