## Appendix KK

**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 at the time of this certification.

_____ Date: _____
Signature