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