Reset Form

Appendix C
Rescission Report

Company Name: _____ Due: March 1 Annually

Company Address: _____

_____

Company NAIC Number: _____

Oklahoma Company Number: _____

Contact Person: _____ Phone Number: _____

Line of Business: Individual: ☐ Group: ☐

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.

Policy Form No.	Policy and Certificate No.	Name of Insured	Date of Policy Issuance	Date(s) Claims(s) Submitted	Date of Rescission

Detailed reason for rescission: _____

_____

_____

_____

_____

_____
Signature

_____
Name and Title

_____
Date

Ref: See 365:10-5-44.1(e). Maintain record of rescissions.