Policyholder Long-Term Care Partnership (LTCP) Plan Status Form

[Issuer Letterhead]

LONG-TERM CARE PARTNERSHIP PLAN 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 meets 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. Date this form was completed _____

13. The name, phone number and email address of the person completing this form
    _____ Name and Title
    _____ Phone Number
    _____ Email Address

I hereby certify that the above information is true and accurate and that the coverage meets partnership plan requirements in Wisconsin at the time of this certification.

Signature _____

Date: _____