(Company Name)

Certification of Information

Florida Annual Long Term Care Claims Denial Reporting

Scope Period: January 1, 20___ through December 31, 20___

(Beginning Date through Ending Date)

I, ___________ (Name of Company Officer – Must be NAIC recognized), do hereby certify that I am currently the ___________ (Title) ___________ of ___________ (Company Name) ___________ and as such do hereby certify that the responses on the attached report are true and accurate regarding the Company’s Compliance with the Annual Long Term Care Claims Denial Reporting for the calendar year ___________ through ___________.

(Beginning Date through Ending Date)

___________________________________
Signature of Company Officer

___________________________________
Date

___________________________________
Title – Must be an NAIC-recognized officer

Subscribed and sworn to before me on this ________ day of

__________, 20___

___________________________________
(Notary Signature), Notary Public

(Please include your printed name, ink stamp or highlighted seal)