(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)