

**RESCISSION REPORTING FORM FOR  
LONG-TERM CARE POLICIES  
FOR THE COMMONWEALTH OF VIRGINIA  
FOR THE REPORTING YEAR 20[ ]**

Company Name: \_\_\_\_\_

Company NAIC Number: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Due: March 1 annually

**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 #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission:

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name and Title (please type)

\_\_\_\_\_  
Date