



State of Nevada
Department of Business & Industry
Division of Insurance
RESCISSION REPORTING FORM FOR
LONG-TERM CARE INSURANCE CONTRACTS

Reporting Year: _____ Date: _____ Due: Annually on March 1

Company Name: _____

Address: _____

Phone and Email: _____

Instructions: The purpose of this form is to report all rescissions of long-term care insurance contracts or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

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

Detailed reason for rescission: _____

* "Contract" here means 'Long-Term Care Insurance Contract'.

 Signature

 Name and Title (please type)

 Date

Reports are required by NAC 687B.004 to be submitted electronically via SERFF at <https://login.serff.com/index.html> (use TOI "Required Industry Reports"). Related inquiries may be made to productcompliance@doi.nv.gov, or mailed to:

Department of Business and Industry
Division of Insurance – ATTN: Life and Health Section
1818 East College Parkway, Suite 103
Carson City, NV 89706