(Company Name)

Certification of Information

Florida Long-Term Care Replacement and Lapse 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 Florida Long-Term Care Replacement and Lapse Reporting Form data call 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)