(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.

_____ _____
Signature of Company Officer *Date*

_____
Title-Must be an NAIC recognized officer

Subscribed and sworn to before me on this *(date)*_____ day of

*(month)*_____, 20 ___

(notary signature) _____
(*Notary Name*), Notary Public
(Please include your printed name, ink stamp or highlighted seal)