(Company Name)

Certification of Information

Florida Long-Term Care Rescission 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 Long-Term Care Rescission 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)