



HOME AND COMMUNITY SERVICES

Long-Term Care Partnership (LTCP) Asset Designation

FOR OFFICE USE ONLY

CLIENT ID NUMBER

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
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Part A. This section must be completed by the insurance company that issued your LTC Partnership Policy (LTCP).

NAME OF INSURED

POLICY / CERTIFICATE NUMBER

EFFECTIVE DATE OF COVERAGE

This policy / certificate was issued in the state of: _____

Date policy issue: _____

The current cumulative dollar amount of insurance benefits paid: \$ _____

The current total dollar amount of insurance benefits remaining available under the policy:
\$ _____

NAME OF PERSON COMPLETING THIS FORM

INSURANCE COMPANY PHONE NUMBER

E-MAIL ADDRESS OF INDIVIDUAL FROM INSURANCE COMPANY COMPLETING PART A

INSURANCE COMPANY NAME

ADDRESS OF INSURANCE COMPANY

**I hereby certify the above information is true and accurate and
that the coverage has partnership status in Washington at the time of this certification.**

Meets LTCP criteria **Does not meet LTCP criteria based on Chapter 284-83 WAC**

SIGNATURE OF INDIVIDUAL FROM INSURANCE COMPANY COMPLETING PART A

DATE

Barcode label



