**Department of Consumer & Business Services**
Insurance Division

**Exhibit 4**
**OAR 836-052-0531**

# Approved Long-Term Care Partnership Program Policy Summary

1. Name of insured: _____
2. Policy/certificate number: _____
3. Effective date of coverage: _____
4. The policy/certificate was issued in the state of: _____
5. The cumulative dollar amount of insurance benefits paid: $ _____
   (Note: The indicated amount does not include any payments for cash surrender, return of premium death benefits, or waiver of premium, and, if joint coverage, the amount is for the indicated insured only.)
6. The total dollar amount of insurance benefits remaining available under the policy: $ _____
7. As-of date, for which this form was completed: _____
8. The name, phone number, and e-mail address of the person completing this form:

   Name: _____

   Phone number: _____

   E-mail address: _____

I hereby certify that the above information is true and accurate and that the coverage ☐ meets ☐ does not meet partnership status in Oregon at the time of this certification.

_____ _____
Signature Date