**Exhibit 1**
OAR 836-052-0576(7)

**RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES FOR THE STATE OF _____ FOR THE REPORTING YEAR 20[ ]**

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1 annually

**Instructions:**

**The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.**

| Policy Form # | Policy and Certificate # | Name of Insured | Date of Policy Issuance | Date/s Claim/s Submitted | Date of Rescission |
|---|---|---|---|---|---|
| | | | | | |

**Detailed reason for rescission:**

_____

*Signature*

**Name and Title (please type)**

*Date*