



Long Term Care Confinement Certificate

CONTRACT INFORMATION

CONTRACT NUMBER

OWNER NAME (First, Middle, Last)

SOCIAL SECURITY NUMBER / TIN

ANNUITANT NAME (First, Middle, Last) - if different

SOCIAL SECURITY NUMBER

PHYSICIAN'S STATEMENT

It is my recommendation that the Owner/Annuitant be confined in a Long Term Care Facility. Such confinement is required because of an injury, sickness or disease.

PHYSICIAN NAME (Printed)

LICENSED STATE

Sign Here _____
SIGNATURE OF PHYSICIAN

Date _____

LONG TERM CARE FACILITY STATEMENTS

Please have the following statements completed by an individual authorized to release such information.

FACILITY NAME

For all contracts

Is the Owner/Annuitant receiving Skilled Nursing or Intermediate Care services? Yes No

Over what period of time has the Owner/Annuitant been confined? **FROM (MM/DD/YYYY)** **TO (MM/DD/YYYY)**

Complete the following for New Momentum, SPDA Series II, AnnuChoice, Pinnacle, and JourneyMark contracts

Is the facility named above: (1) a hospital licensed by the state; recognized by the Joint Commission on Accreditation of Hospitals; or certified as a hospital by Medicare; or, (2) a nursing home licensed by the state; or (3) a facility certified by Medicare as a long-term care facility? Yes No

Does this facility provide continuous 24 hours a day nursing care? Yes No

CERTIFICATION BY INDIVIDUAL AUTHORIZED TO RELEASE INFORMATION

NAME (First, Middle, Last)

TITLE

BUSINESS PHONE

Sign Here _____
SIGNATURE OF AUTHORIZED INDIVIDUAL

Date _____

