



Assignment of Benefits Form



Name of insured

First name	M.I.	Last name

Provider information (where payment is to be sent)

Facility/agency or provider name

Tax ID or Social Security number

Payment address

City	State/Territory

Country	Zip/Foreign postal code

Phone number				

Assignment of Benefits

I authorize payment to be paid to the provider shown above for long term care insurance benefits otherwise payable to me. I understand I am financially responsible to the named provider for the charges not paid or payable under this Program. I understand that Long Term Care Partners may not be able to honor this request. If they cannot, they will pay the benefits directly to me as the insured.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I certify that the information furnished in support of this claim is true and correct.

Signature (Insured person or legal representative) _____

Date signed ____ / ____ / ____