

NP PASSIVE EXCHANGE CONFIRMATION LETTER

[DATE]

[FIRST NAME] [MI] [LAST NAME]  
[ADDRESS LINE 1]  
[ADDRESS LINE 2]  
[CITY] [STATE] [ZIP CODE]

Policy Number: [00000-00000]

Dear [First Name] [Last Name]:

Our company participates in [original execution state]'s long-term care partnership program by offering long term care insurance policies that meet certain state and federal requirements. Under the partnership program, policies that meet these requirements may allow you to protect a portion of your assets from Medicaid's "spend down" requirements if you should ever need to apply for Medicaid benefits to pay for long term care expenses in the future. Partnership program policies may allow you to keep a dollar of your own assets for every dollar of benefits paid by the policy for long term care services should you need to apply for Medicaid.

Your current policy benefits already meet the requirements of the Partnership Program in your state. The only change needed to qualify your policy for the Partnership Program is a new coverage effective date. This new coverage effective date will not change your policy benefits or premium, and you will not lose any rights, benefits, or built-up values that have accrued since the issue of your policy.

**Therefore, we have automatically changed the coverage effective date of your policy, to make sure your policy qualifies for the Partnership Program.** Enclosed is a new Schedule of Benefits page for your policy, showing the new coverage effective date, and your Partnership notice.

If, after reviewing this letter, you decide to reject this exchange, simply sign and date the bottom portion of this letter and mail it with the Schedule of Benefits page and Partnership notice to our office using the enclosed envelope. Your policy will continue in force with the original effective date as long as you continue to pay your premiums, but will not qualify for your state's Long-Term Care Insurance Partnership Program.

If you have any questions about your long-term care coverage, please call us at «grp\_cs\_phone». Our Customer Service Representatives are available «grp\_cs\_hours».

Sincerely,

[Administrator]  
«grp\_program»

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**I reject the exchange offer and do not want my policy to qualify for the Long-Term Care Insurance Partnership Program.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Policy Number: [00000-00000]