

9393

VOID CORRECTED

PAYER'S name, street address, city, state, ZIP code, and telephone no.		1. Gross long-term care benefits paid \$	OMB No. 1545-1519
		2. Accelerated death benefits paid \$	2003 Long-Term Care and Accelerated Death Benefits
PAYER'S Federal identification number	POLICYHOLDER'S identification number	3. Check one: <input type="checkbox"/> Per diem <input type="checkbox"/> Reimbursed amount	Form 1099-LTC
POLICYHOLDER'S name		INSURED'S name	
Street address (including apt. no.)		Street address (including apt. no.)	
City, state, and ZIP code		City, state, and ZIP code	
Account number (optional)	4. Qualified contract (optional)	5. Check, if applicable (optional): <input type="checkbox"/> Chronically ill <input type="checkbox"/> Terminally ill	INSURED'S social security no.
Form 1099-LTC		41-1628061	Department of the Treasury - Internal Revenue Service

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