**Western-Southern Life Assurance Company**
**Cincinnati, Ohio**

**Return completed form to:**
Annuity Operations Group
P.O. Box 2918
Cincinnati, OH 45201-2918
**For assistance in completing this form, call 1-800-926-1702**

# Long Term Care Confinement Certification

**Contract Number:**

OWNER

| **Name** | **Social Security Number** |
|---|---|
| | |

ANNUITANT (complete only if different from owner)

| **Name** | **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.

**Printed Name of Physician** _____

**Signature of Physician** _____

**Licensed in the State of** _____

LONG TERM CARE FACILITY STATEMENTS

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

- Name of facility _____
- Is this facility operating as a state licensed Skilled Nursing or Intermediate Care Facility according to the law of the jurisdiction in which it operates? **Yes**___ **No**___
- Does this facility provide continuous 24 hours a day nursing care under the supervision of a physician, registered graduate professional nurse (R.N.), or licensed practical nurse (L.P.N.)? **Yes**___ **No**___
- Does this facility maintain daily records of each patient? **Yes**___ **No**___
- 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** _____ **To** _____

**Printed Name of Individual Authorized to Release Information** _____

**Signature of Authorized Individual** _____ **Date** _____

**Title** _____ **Business Phone (  )** _____