The Federal Long Term Care Insurance Program™

Assignment of Benefits Form

Insured's name

First name M.I. Last name

This Assignment of Benefits (AOB) form is used to assign benefits directly to your provider.* Once your plan of care has been established, you may submit the completed form. Your provider must also complete and submit the attached W-9 form. Only one AOB form and one W-9 form are required per provider per claim.

The AOB ends when the claim ends. If a new claim is opened, a new AOB form must be submitted after a plan of care has been established. In order to cancel an AOB, a letter, signed by the insured or the insured's legal representative, must be submitted requesting that reimbursement be issued to the insured.

***An AOB is only available for home care agencies and facilities within the United States.**

Provider information (where payment is to be sent)

Facility/agency's or provider's name

Federal Employer Identification number

Payment address

City State

Zip 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 the Federal Long Term Care Insurance Program. I understand that Long Term Care Partners (LTCP), LLC, 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.

Note: A handwritten signature is required.

Signature (insured or legal representative)

_____ **Date signed** ____ / ____ / ____

(Required) (Required: mm/dd/yy)

Please return your completed AOB and W-9 forms by email to **claimsinfo@ltcpartners.com,** by fax to **1-866-513-2674,** or by mail to **Long Term Care Partners, LLC, P.O. Box 797, Greenland, NH 03840-0797**.

The Federal Long Term Care Insurance Program is sponsored by the U.S. Office of Personnel Management, insured by John Hancock Life & Health Insurance Company, and administered by Long Term Care Partners, LLC.

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