APPENDIX C

SURVEY REPORTING FOR JANUARY 1, 2005 THROUGH DECEMBER 31, 2008

Name of Carrier:	<Insert Company Name here>
NAIC#:	<Insert NAIC# here>
Contact/Title:	<Insert Contact/Title>
Address:	<Insert Address here>
Telephone:	<Insert Telephone Number here>
FAX:	<Insert FAX Number here>
E-Mail Address:	<Insert E-Mail Address here>
Original File Date:	<Insert original filing date here>
Revision Date (If applicable):	<Insert revision date(s) to filing here>

Instructions:

IF YOUR COMPANY INSURES MASSACHUSETTS RESIDENTS IN GROUP ***AND*** INDIVIDUAL LONG TERM CARE INSURANCE POLICIES, PLEASE SUBMIT A SEPARATE SET OF RESPONSES.

The responses to this questionnaire pertain to:	**Place a checkmark (√) next to the applicable type of business**
1. GROUP business	
2. INDIVIDUAL business	

If your company is selling a "stop loss" product, administrative services only, or reinsurance long-term care to a self-funded plan, please check here. _____
(Please do not include information on this questionnaire about such "stop loss," administrative services only, or reinsurance for long-term care to a self-funded plan product.)

PLEASE RETURN BY NO LATER THAN WEDNESDAY, APRIL 22, 2009

By e-mail: maryanne.walsh@state.ma.us

THE STATEMENTS AND ANY ATTACHMENTS AND ENCLOSURES ACCOMPANYING THIS REPORT REPRESENT MY ORGANIZATION'S PARTICIPATION IN THE LONG-TERM CARE INSURANCE MARKET.

Print Name and Title

Signature

Date