CALIFORNIA DEPARTMENT OF INSURANCE
Statistical Analysis Division

LONG-TERM HEALTH CARE FACILITIES and
RESIDENTIAL CARE FACILITIES DATA CALL
(LTCF-2009)

AFFIDAVIT

State of _______________________________)
County of _____________________________)

________________________________________ (*), being duly sworn, deposes and says that he/she is the
(name of company official responsible for compilation of data)__________________________of the ________________________________; confirm that the statistical data
(title of company official) ____________________ (company name)
reported in the 2009 LTCF Data Workbook is a true and accurate compilation of the insurance
experience data, required under CIC 674.9 (b) 1-11, for the period covered to the best of his/her
knowledge, information and belief.

________________________________________
(Affiant - signature)*

Subscribed and sworn to (or affirmed) before me on this _____ day of __________________, 20____,
by _________________________________(Affiant – print)*, proved to me on the basis of
satisfactory evidence to be the person(s) who appeared before me.

(seal) Signature _________________________________

* Affiant must be company official responsible for the compilation of the data filing.

A COPY OF THIS FORM MUST ACCOMPANY EACH FILING OF EXPERIENCE.