

**Continuing care provider
Certification of changes to disclosure statement**

► Certification

I, _____ do certify that I am an officer of
Officer

_____ with the title of
Provider/facility

Title

I also certify that: (1) I am familiar with the statues and rules governing Continuing Care Facilities, (2) I am responsible for the filings submitted to the Texas Department of Insurance in regard to the disclosure statement, (3) I have personal knowledge of the submission of all items in regards to this disclosure statement, and (4) the attached revisions, as indexed below, constitute the only change, additions, and deletions to the disclosure statement.

📎 Attach a list of revisions with the following details:

- Description of change
- Subsection
- Page no. or name of attachment

Signed by officer _____ Date _____

State of _____ County of _____

Sworn to and subscribed before me on the _____ day of _____, 20_____.

Notary public signature

(Seal)

Notary printed name

My commission expires _____