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SUPERINTENDENT

STATE OF NEW YORK
INSURANCE DEPARTMENT
324 STATE STREET
ALBANY 10

September 20, 1963

TO INSURERS LICENSED TO WRITE LIFE OR
ACCIDENT AND HEALTH INSURANCE IN NEW YORK STATE

For your information and guidance in the preparation and submission of forms for review by this Department pursuant to Section 154 of the Insurance Law, I am enclosing copies of guidelines in current use by Policy Bureau examiners in considering individual and group forms of life and accident and health insurance. Similar guidelines with respect to blanket and franchise accident and health policies and wholesale life policies are now being compiled.

These guidelines, compiled at Superintendent Thacher's direction to assist in the internal operation of the Policy Bureau, are subject to amendment from time to time, but it is planned to publish supplements to this initial compilation annually in order to keep them as current as practicable. A restatement of Department requirements affecting the filing of proposed forms and rates of accident and health insurance and of life insurance is now in preparation.

To expedite processing of proposed forms submitted to the Policy Bureau, the filing letter which accompanies a form deviating from the guidelines should call attention to the deviation and explain how it meets applicable Insurance Law requirements.

Very truly yours,

Raymond M. Defossez

Raymond M. Defossez
Deputy Superintendent

Enc.

Circular Letter 63-4

GUIDELINES FOR EXAMINATION OF INDIVIDUAL LIFE POLICIES AND RELATED FORMS

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I. GENERAL REQUIREMENTS

A. Title and Brief Description

1. The words "Return of Premiums", "Death Benefit Plus Cash Value", "Death Benefit Plus Reserves" or similar terms used to describe an additional increasing term benefit equal to the premiums, reserves or values will not be acceptable descriptions. Nevertheless, such additional amounts may be described substantially as amounts equal to the premiums etc., provided the text of the benefit indicates the true nature thereof.

B. Legibility of Forms

1. Forms printed in type which conforms to the minimum requirements with respect to Individual A & H Forms, pursuant to Section 164. 2(4) of the Insurance Law are acceptable. The Department may require improvement in legibility in any case where printing (which does not conform to such minimum requirements) is, in fact, below a reasonable standard of legibility.

II. ORDINARY PLANS

A. Reserves and Values

1. The values shown in the non-forfeiture table (if other than on a $1,000 unit basis) should be based upon units not greater than the minimum face amount of the death benefit for which the policy will be issued.

B. Preferred Risk or Select Risk Plan

1. A plan may not be labelled or designated as a preferred or select risk plan if the insurer has another approved plan which is identical therewith but not so labelled or designated.

2. The word "Special" should not be used to describe preferred risk or select risk plans.

C. Premium Reductions Based on Insurance Amounts

1. The filing of plans which will be issued with premiums graded by amounts of insurance must be accompanied by a statement of the insurer's method of grading premiums.

D. Juvenile Plans

1. Limitation of Benefits Provision

Plans to which Section 147 of the Insurance Law is applicable must contain a provision, by rider or otherwise, which will substantially reflect the requirements of that section,

2. Payor Benefit Age Adjustment

Any provision for age adjustment must include both the ages of the insured and the payor and must be based upon the aggregate premium paid for all benefits.

E. Policy Benefits

1. Loans

Any provision in relation to the effect of failure to repay a loan shall not indicate that exhaustion of the insured's equity will render the policy void, unless at least 30 days' prior notice shall have been given.

2. Automatic Premium Loans

(a) The automatic premium loan provision included in the policy shall indicate that it is effective only if elected and that such election is subject to revocation. Any such provision shall be clear as to the right to resume premium payments as specified in the policy at any time.

(b) If any limitations are imposed upon the number or amount of premiums which may be subject to the provision, the fact of such limitations shall be referred to in a proper caption.

(c) In connection with any such provision, the policy shall clearly indicate how the provision will apply in the event that the loan value is insufficient to pay the stated premium due and the disposition of any sums not used to pay premiums.

(d) Any automatic premium loan provision should be separately captioned and not included under or with the non-forfeiture provisions.

F. Dividends

1. All non-participating plans must contain a statement in the brief description on the face page and also on the filing back, if one is used, indicating that the plan is non-participating or does not share in surplus earnings.

2. Whenever one year term insurance is purchased by dividends in connection with a policy, it shall provide for an equitable adjustment in the event of termination of the policy (other than by death) prior to the expiration of such one year term insurance.

3. Any additional supplemental benefits attached to a participating policy, whether or not considered in determining surplus earnings, may not be specifically labelled or described as non-participating.

G. Non-Forfeiture Benefits

1. Substandard plans in which the extended insurance option is deleted shall indicate by proper text in the policy and/or endorsements that such option and values are not applicable.

2. Tables which contain headings and spaces for the insertion of extended insurance values must be printed, overprinted or stamped in a prominent manner to indicate that such values are not applicable in all cases in which such values are not granted.

H. Required Provisions

Grace Period

1. With respect to renewable term insurance, the insured shall have a grace period of 30 days or one month within which the payment of any premium after the first may be made, including any premium for renewal of such insurance.

Incontestability Provision

2. If any exceptions are made with respect to the applicability of the incontestability provision to any non-cancellable total and permanent disability benefits included in the policy or attached by rider, then such contract must include an incontestability provision which will conform with the requirements of Section 158 of the Insurance Law.

3. Whenever preliminary term insurance is issued to precede a longer term plan of insurance, such preliminary term rider or other form may contain suicide and incontestability provisions, and the successor plan must provide in substance that the time periods of those clauses shall be computed from the date of issue of the preliminary term insurance coverage.

4. All policies which contain guaranteed insurability purchase options, whether "built-in" or provided by rider, shall contain a statement to the effect that the period of incontestability specified in any policy issued as a result of the option shall date from the issue date of such option agreement.

5. The incontestability provision of any policy issued as a result of a guaranteed insurable purchase option shall clearly provide in the text thereof or by means of endorsement or rider that the time period shall be computed from the issue date of the purchase option agreement.

6. Any policy issued pursuant to the terms of a conversion option must be in compliance with the requirements of the Department Circular Letter of March 27, 1939.

Entire Contract

7. The "Entire Contract Clause" shall not include the words "In the absence of fraud".

Misstatement of Age

8. In all plans where the premiums, benefits or values differ depending upon the sex of the insured, the misstatement of age provision may include a provision for adjustment in the event of misstatement of sex.

9. The misstatement of age or sex provision must not refer solely to the insurer's published rate for determination of adjusted benefits for the reason that the insurer may have no such published rate for the correct age or sex.

I. Exclusions, Limitations and Exceptions

1. Any suicide exclusion provision shall not include the words: "While sane or insane". This prohibition does not apply to additional benefits in the event of death by accident.

2. Any suicide exclusion stated in a contract based upon a guaranteed purchase option shall conform with the provisions of such option agreement.

J. Settlement Options

1. If any life income optional settlement with a period certain provides for installment payments of the same amount at some ages for different periods certain, the contract must provide that the insurer will deem an election to have been made for the longest period certain which could have been elected for such age and amount.

K. Endowment Plans

1. The maturity value or endowment sums payable should not be described as a "fund".

L. Term Insurance

1. The brief description of each level term policy, other than term to a specified age, must state whether the policy is renewable, convertible, non-renewable or non-convertible.

2. Renewable policies (other than employer-employee plans) in which the premium increases with age, or benefits correspondingly decrease, must be limited to a maximum age of 70 years.

3. Any title, caption or description using the words "Life Expectancy", or "Term to Expectancy" or similar words is considered misleading and unacceptable.

4. Any policy which grants a right of conversion to any insured person, shall not deny a conversion right to any insured who is, or during the term of that policy has been, disabled. The right of a disabled person to convert may be postponed to the last date on which any insured person may convert. This will not preclude a requirement that supplemental benefits, such as a disability benefit provision, may be included in the converted policy only upon satisfactory evidence of insurability.

5. Conversion periods should bear a reasonable relationship to the term of coverage.

6. Any provision relating to the risk classification of the conversion policy must provide that such classification will not be less favorable than the classification of the insured in the policy or rider from which he converts. This is not required with respect to employer-employee or association plans.

III. FAMILY PLANS

A. Termination of Insurance

1. Any provision terminating insurance by reason of family status or residence will not be approved.

B. Juvenile Insurance Limitations

1. The policy must contain a limitation of benefits provision, by rider or otherwise, reflecting the requirements and prohibitions of Section 147 of the Insurance Law. Any statement in relation to refund of excess premiums may specify a dollar amount or an amount as provided in a schedule filed with the Superintendent, and such schedule shall accompany the submission letter.

C. Beneficiary Provision

1. The applicant must be given the right to designate the beneficiary in the application, and the policy must contain a provision granting the right to change the beneficiary designation.

D. Conversion

1. Term insurance on spouse or children must either be convertible on the expiry date or be clearly noted as non-convertible in the brief description.

2. The policy text should provide that the incontestable and suicide provisions of any conversion policy will be effective from the date of coverage of the family policy and that the conversion policy will be so endorsed. Otherwise, the insurer must give assurance that such conversion policy will be endorsed to provide that the incontestable and suicide provisions will be effective from the date of coverage under the family policy.

3. If any application will be required for conversion, such application must be approved.

4. The minimum period for terminal conversion must be not less than 30 days prior to expiry date.

5. It must be stated that the rate classification of the conversion policy will be the same as or more favorable than the classification in the original policy.

E. Required Provisions

Reinstatement

1. The policy must contain a provision that it will be reinstated upon submission of evidence satisfactory to the company of insurability of the insured in a one parent policy or the insured and insured wife in a two parent policy. The company may require evidence of insurability as to each other person to be insured at the date of reinstatement, and if the evidence of insurability furnished by any such person or persons is not satisfactory, such person or persons will be excluded from coverage by endorsement upon completion of reinstatement. The clause may also provide that there shall be no liability with respect to any person who shall have died between the date of lapse and the date of reinstatement.

Age Adjustment

2. The age adjustment provision may be made applicable to all persons covered under the contract.

Suicide

3. Any provision relating to suicide of any person other than the principal insured shall not make the policy void or affect benefits granted other than benefits promised pertaining to the death of the person committing suicide.

4. In the event of a death as to which there is a suicide exclusion where the company is required by Insurance Law Section 155.2 to pay the amount of the gross premiums (less dividends) and (less indebtedness), the company cannot offset from such sum the amount of any benefits previously paid under the policy.

IV SUPPLEMENTAL BENEFITS

A. Disability Benefits

1. The definition of disability as stated in Section 158 of the Insurance Law should be suitably modified to define properly total and permanent disability as applied to children, provided such definition is in substance within the scope of the present statutory definition.

2. Total disability must be defined, in substance, as "Incapacity of the insured. . . to engage in any occupation for remuneration or profit" or language more favorable to the insured. Clauses referring to work or occupation not in each case predicated on remuneration or profit will not be accepted.

3. Where reference to permanency is included in a provision, the word "presumed" in connection with the qualifying period for determination of permanency will not be acceptable in lieu of the word "deemed".

4. There should be no specific time limit for the giving of notice and proof of claim except in accordance with Section 158 of the Insurance Law.

5. The notice of claim provision in Section 158.2(c) requires that notice be "given to" the insurer. The words "received by" are not considered to be as favorable to the insured and are not acceptable.

6. Any requirement in relation to the furnishing of additional proof of continued disability should use substantially the language prescribed in Section 158 of the Insurance Law in relation thereto and should not grant the right to the insurer to require such proof at "any time" or "whenever requested".

7. Any provision with respect to misstatement of age may not provide that the benefit will be void if the correct age is an ineligible age for the issuance of the benefit.

8. Any limitation of coverage by reason of military service which does not terminate the benefit must be so worded that it clearly indicates the intent to exclude only disabilities resulting from war or an act of war, or service in the military, naval or air forces of any country at war.

9. Exclusions of disabilities resulting from self-inflicted injuries must use substantially the language of Section 158.3(a) (3) of the Insurance Law.

10. Any clause terminating coverage upon default of premium shall provide only for such termination at the end of the grace period.

11. Income benefits for a specified period such as 10 years or to age 65 are not properly included in an individual life contract. This is not intended to preclude clauses which carry the benefit to the specified maturity date nor the common type of income disability provision wherein the policy automatically matures as an endowment at age 65 and income payments stop at that time.

12. Any clause providing for termination because of entering military service shall provide for discontinuance of the applicable premium and refund of any such premium that has been paid for any period after such termination.

13. No termination provision shall invalidate or diminish any benefit for which the insured has qualified.

14. Each waiver of premium form shall provide that where a claim for benefits is valid, the company will waive the payment of all premiums due on the policy, including all supplementary provisions forming part of the policy. It is understood that this provision does not apply to any provision for additional one-year term insurance which may be purchased at the insured's option under a "fifth dividend option" provision.

15. Each renewable term policy containing waiver of premium benefits, by rider or otherwise shall provide in substance that if, on any policy renewal date the insured is receiving, or is entitled to receive disability benefits, the policy renewal shall be automatic.

16. The incontestability clause of each payor benefit form which provides benefits in the event of (a) death, or (b)disability, must be so drafted that it will apply to both benefits, or at the option of the company there may be a separate incontestability clause applicable exclusively to the disability benefit.

B. Accidental Death Benefits

1. Additional benefits for accidental death sold in multiples of the face amount must bear a reasonable relationship thereto and, in any event, shall not be for an amount in excess of 5 times the face amount of the policy.

2. A clause is not approvable which would invalidate benefits otherwise payable for death by accident by reason of medical or surgical treatment for injuries causing such death.

3. Any provision which contains an exclusion or limitation of coverage in the event that the insured is receiving, or is eligible to receive, benefits under any disability provision of the contract, is not approvable. This rule is not intended to prohibit a provision reducing the amount of accidental death benefit payable by the amount of benefit paid as a result of loss of sight or limbs because of the same injuries.

4. Forms will not be approved if they provide that proof of claim must be furnished to the insurer within any specified period of time after the death of the insured, unless a provision substantially the same as the following is also included:

> Failure to furnish such proof within the specified time will not invalidate a claim if it is shown that it was not possible to furnish proof within the specified time and that proof was furnished as soon as reasonably possible.

C. Guaranteed Insurability Options

1. All options, whether printed in the policy or added by rider, must comply with the Department's Circular Letter of July 23, 1959 and the Department Letter of May 15, 1962 to the Life Insurance Association of America.

2. The option must contain a statement which will restrict the incontestable provision of any new policy as indicated in the Department's Circular Letter of July 23, 1959 and the Department Letter of May 15, 1962 to the Life Insurance Association of America.

3. The option must contain a provision restricting the suicide exclusion of any new policy as stated in the Department's Circular Letter of July 23, 1959 and the Department Letter of May 15, 1962 to the Life Insurance Association of America. In lieu of printing such provision in the text of the option, the insurer may accomplish the same by the use of an approved rider or endorsement.

4. If any additional benefits in option policies will require evidence of insurability, it must be clear that such evidence will apply solely to such additional benefits.

5. The insurer must have an approved application, if any will be required for option policies. Such application shall not contain any questions intended to elicit information relative to evidence of insurability, except where additional benefits or amounts in excess of the option amount are applied for, and in such cases it shall be indicated that such evidence shall clearly relate and apply to the additional benefits or increased amounts as the case may be.

V. APPLICATIONS

A. Combination Life and Accident and Health

1. The Insurance Department should have assurance from the company that if the applicant qualifies for one policy and not for the other on the basis of the application, he will be offered the policy for which he qualifies. This rule shall not apply to employer-employee or association plans.

2. The applicant must be permitted to apply for either policy or for both policies. This rule shall not apply to employer-employee or association plans.

B. Questions

1. No application shall contain a question as to race or color.

2. Questions requiring applicant's opinion regarding past or present health of a person proposed for coverage should be asked to the best of the applicant's knowledge and belief.

3. Questions regarding an applicant's past or present health which are phrased so as to require factual information rather than a statement of the applicant's opinion need not be so qualified.

C. Agreements

1. The applicant should not be required to agree or state that he has not withheld any information or concealed any facts.

2. The applicant should not be required to agree that any untrue or false answer material to the risk will or shall render the contract void. This rule shall not apply to industrial life policies.

3. An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application in a space provided for the same is not approvable, except in conformity with Section 142.4 of the Insurance Law.

GUIDELINES

FOR EXAMINATION OF

GROUP LIFE FORMS

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I. POLICIES

A. Form and Composition

1. In addition to any other applicable requirement, all submissions must comply with the Department Filing Rules dated March 3, 1953, as amended.

2. The insurer must submit a statement of the pages which must always be included in a group policy and a list of all optional pages, if any, together with an explanation of the use thereof.

B. Policy Provisions

1. Age may not be the sole condition of eligibility for insurance. Where age is used with other conditions of employment as a condition of eligibility for insurance, the insurer must justify such usage as being compatible with the decision in Dudrey vs. Equitable Life. This shall not preclude the satisfaction of this requirement by a plan comprising more than one group policy.

2. Under subdivision 2 of Section 221, the persons eligible for insurance shall be those employees or union members or all or any class or classes thereof determined by conditions pertaining to their employment, as illustrated by the following examples; geographic situs of employment, compensation for employment, hours of employment, and occupational duties.

3. The maximum coverage for an individual employee, or limited number of employees, under a group contract must be reasonably related both to the total amount of insurance on the group and to the average amount of insurance on each member of the group. See Department Circular Letter of July 19, 1962.

4. The policy should state specifically and clearly all reasons for individual termination of coverage.

5. Directors, per se, are not eligible and must qualify as an "employee" as defined by statute.

6. Retired employees must be granted equitable rights of conversion upon termination of coverage. See Department Circular Letter of June 2, 1953.

7. There may be no agreement in the policy for the deferment of payment of the premium for the first policy year or any portion thereof, in violation of the Department Circular Letters of March 12, 1957, December 18, 1957, and March 3, 1960.

8. There may be no agreement for reimbursement of incurred expenses in connection with the solicitation or administration of the policy, except as provided by the Department Circular Letter of July 16, 1952.

9. Any disability benefit of the type commonly known as "Extended Death Benefit" or "Waiver of Premium" shall not require as a condition for the payment of the death benefit that the death occur while the group policy is in force. See Department Circular Letters of December 20, 1948 and April 28, 1949.

10. The insurer may prescribe up to 12 months as a waiting period within which to establish total and permanent disability. If an individual is still totally disabled at the expiration of the waiting period, he is deemed totally and permanently disabled at that time.

11. Dependents may not be covered for group life insurance.

12. Incorporation by reference is governed by Section 142(1). References to other sources to determine factual situations, such as the facts of employee status, membership in a collective bargaining unit or a union, other benefits, salary, termination of employment or membership, etc., are not incorporations by reference. Where sources outside the group policy are referred to for such data as the plan of benefits expressed in a collective bargaining agreement or trust instrument, etc., such source documents or sufficient excerpts therefrom should, for information purposes, accompany the filing, as part of the file.

II. CERTIFICATES

1. The certificate must contain certifying language.

2. The names of reinsurers may not appear within the certifying language of the certificate.

III. RIDERS

1. Except for riders by which the insurer exercises a specifically reserved right under the policy or which concern only administrative changes, all riders which may be added to the master policy after date of issue and which reduce or eliminate coverage in the policy should provide for signed acceptance by the policyholder.

GUIDELINES FOR EXAMINATION OF INDIVIDUAL ACCIDENT AND HEALTH FORMS

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I. SUBMISSIONS IN GENERAL

1. All submissions must comply with the filing rules set forth in the Department's Circular Letter of January 20, 1954.

2. Submission of a policy should specify the form numbers of any application and other forms then intended for use with the policy, except forms which have been approved for use with any policy of the same class as the policy being submitted.

3. Submission of a rider, application or endorsement should specify the form or class of forms with which it is to be used and the manner in which it is to be used.

4. A form in which the printed text has been changed by crossing out or striking out, except for the effecting of simple administrative alternatives, will not be approved.

II. APPLICATIONS

1. Questions as to race or color are not permitted.

2. Questions requiring applicant's opinion regarding past or present health of a person proposed for coverage should be asked to the best of the applicant's knowledge and belief.

3. Questions regarding an applicant's past or present health which are phrased so as to require factual information rather than a statement of the applicant's opinion need not be so qualified.

4. No provision will be permitted in an application which changes the terms of the policy to which it is attached from those expressed in the policy.

5. If an application is designed so that more than one policy can be applied for, the Insurance Department should have assurance from the company that if the applicant qualifies for any policy applied for on the basis of the application, he will be offered the policy or policies for which he qualifies. This rule shall not apply to employer-employee or association plans.

6. The applicant must be permitted to apply for either policy or for both policies. This rule shall not apply to employer-employee or association plans.

7. The applicant should not be required to agree or state that he has not withheld any information or concealed any facts, but he may be required to state that his answers are true and complete.

8. The applicant should not be required to agree that any untrue or false answer material to the risk will or shall render the contract void. This rule shall not apply to industrial health policies.

9. An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application in a space provided for the same is not approvable, except in conformity with Section 142.4 of the Insurance Law. This rule is inapplicable to impairment riders and exclusion riders.

III. POLICIES

A. General Rules

1. Newly-submitted policies must comply with statutory requirements without the necessity of riders or endorsements to effect conformance therewith unless New York requirements are distinctive from those required in other states or unless riders or endorsements are expressly permitted by statute. Riders may be approved with previously approved policies for the purpose of conforming such policies to changes in the law or in rules and regulations unless the resulting contract in its entirety would have the tendency to mislead or confuse the policyholder.

2. The face page should indicate whether the policy is renewable or non-renewable.

3. Provisions respecting renewability or cancellation by the insurer must appear on the first page or reference must be made thereto in a brief description on the face page and, if the policy has one, on the filing back.

4. Any reduction in benefits because of the attainment of an age limit must have a reference to such reduction set forth on the first page. For purposes of this rule, a reduction in a benefit period is a reduction in benefits requiring such reference.

5. The terms "non-cancellable" or "non-cancellable and guaranteedrenewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy (1) until at least age fifty, or (2) in the case of a policy issued after age forty-four, for at least five years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

6. Except as provided in the preceding paragraph, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums (1) until at least age fifty, or (2) in the case of a policy issued after age forty-four, for at least five years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

7. The words "guaranteed renewable" cannot be used in a policy unless the insurer's right to change rates is also stated in such a way that it is not minimized or made obscure.

8. Accidental injury benefits may not be predicated upon loss occurring through "Accidental Means" or "Violent and External Means".

9. The insurer may be required to justify its proposed probationary periods as being reasonable and not misleading or productive of illusory benefits. The following probationary periods in individual accident and sickness policies are considered reasonable:

(a) Loss due to accidental injury -------- None
(b) Loss due to all sickness ---------- Thirty days
(c) Loss due to specified sickness ------- Six months

10. No policy shall contain a provision for its automatic termination upon the happening of any loss except a loss which has exhausted all possible benefits under the policy.

11. No policy provision may exclude disease of the female generative organs for more than six months. This does not prohibit specific use of an appropriate impairment rider.

12. In any policy which provides for a suspension of coverage while the insured is in military service, the policy shall provide that upon written request, the insurer will refund any unearned premiums for the period of such suspension.

13. A policy providing maternity and obstetrical benefits must provide for an extension thereof where required by and in accordance with the Department's Circular Letter of January 23, 1940 in connection with a cancellation or refusal to renew by the insurer.

14. When the optional standard provision entitled "Insurance With Other Insurers" is used, the application must request information as to such other insurance.

15. No policy may contain a provision excluding benefits under any other individual insurance or pro-rating benefits under any other insurance except in conformity with applicable portions of the New York Insurance Law such as Sections 164-2(B)(3), 164-3(B)(3), 164-3(B)(4), 164-3(B)(5), 164-3(B)(6), 164-3(C) and 164-6.

16. Family policies may provide for a new contestable period for each new member added, but may not provide for a new contestable period for the policy.

17. Nurse benefits may be provided either with a maximum or on a coinsurance basis or both. The policy should define the type of nurse for whom payments will be made and should not use the term "trained nurse" unless prepared to accept licensed practical, registered and Christian Science nurses.

18. All policies which contain unusual exclusions, limitations, reductions or conditions of such a restrictive nature that the payments of benefits under such policies are limited in frequency or in amounts, should be identified by the legend "This Is A Limited Policy -- Read It Carefully" imprinted in not less than eighteen point outline type diagonally across the face of the policy.

B. Accidental Death and Dismemberment Policies

1. Any accidental death and dismemberment benefits must be payable when the loss occurs within ninety days from the date of the accident, irrespective of total disability.

2. Filing of vending machine policies should be accompanied by information describing the operation of the machine. Information and directions, which will be obtained from the machine itself, should also be included.

3. Dismemberment benefits may not be in lieu of loss of time benefits unless the dismemberment benefit is greater than the maximum loss of time benefit. The policy may provide for payment of the greater benefit or both.

4. If the policy contains an exclusion for injuries or death as a result of self-destruction or self-inflicted injury, such exclusion shall be limited to intentional self-destruction or intentionally self-inflicted injury; however, an exclusion for death or disability as a result of suicide, or any attempt thereat, while sane or insane, or disability as a result of self-inflicted injury while insane, is approvable.

C. Loss of Time Policies

1. Such policies may not require the loss from accidental injury to commence within less than thirty days after the date of an accident. Nor may any such accident policy, which the insurer may cancel or refuse renewal, require that it be in force at the time the loss commences.

2. Benefits for specific accidents, if any, may be minimums but may not be in lieu of loss of time benefits, unless the specific benefit is greater than the policy for actual loss of time suffered.

3. Policies which limit benefits for loss of time to specified items (such as business overhead policies) must provide for a premium refund, in accordance with a short rate table, in the event that none of the items to be indemnified exist (e.g. where a professional person discontinues his office), but only if the insured gives timely notice. Any premium refund may be limited to one year's premium.

4. No reduction of benefits by reason of a change in employment status, or change in income of insured is permitted, unless the optional standard provision entitled "Change of Occupation" or "Relation of Earnings to Insurance", whichever is applicable, is used.

5. A loss of time policy insuring employed females may provide for a reduction in the amount of periodic indemnity if the insured is not employed on a full-time basis away from her residence at the time disability commences, subject to the following limitations:

a) With respect to a person insured at the insurer's most favorable occupational class, the reduction may not exceed 50%;
b) With respect to a person insured at a less favorable occupational class of the insurer, the reduction must produce a periodic indemnity reasonably consistent with one-half the amount which the premium paid would have purchased at the insurer's most favorable occupational class.

6. Benefits for confining sickness will not be acceptable unless there is also an appropriate benefit for non-confining sickness. The indemnity for non-confining sickness may not be less in amount than for confining sickness. The benefit period for non-confining sickness may not be less than one-fourth of the period for confining sickness, except that no more than one year will be required for non-confining sickness benefits, and for confining periods of six months or less, only one month or four weeks of non-confining sickness benefits will be required.

7. Loss of time benefits conditioned upon hospital confinement or surgery shall be considered as hospital or surgical expense benefits for purposes of Sections 164-2(B)(3) and 164-6.

8. Dependents' loss of time benefits are approvable provided the provision adequately defines the conditions establishing disability.

D. Hospital or Surgical Policies

1. Termination of the policy must be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period while the policy was in force may be predicated upon the continuous total disability of the insured.

2. Different maximum daily benefits should not be provided because of the kind or type of hospital accommodations.

3. Surgical schedules may not contain internal catch-all provisions which would include major operations unless the amount payable for such catch-all is at least equal to the maximum allowed under the general surgical catch-all.

4. Surgical schedules must contain a general catch-all provision for operations not listed and notexcepted, and providing for consistent payment with items listed. Where payment is to be made for fractures or dislocations, the general catch-all provision must include such items, either by specific reference or by covering all surgical procedures.

5. Where a surgical schedule purports to pay definite amounts, either by specifying the amounts or by indicating units which are to be multiplied by a dollar amount, the benefit provision may not provide that a percentage less than 100% of such amounts will be paid. This rule is not intended to prevent the use of coinsurance, deductible or expense incurred provisions.

6. If miscellaneous benefits are omitted, explanation should be given in the filing letter, such as, where the policy is written to supplement benefits of a previously issued in force policy, or where the minimum daily indemnity is large enough to cover miscellaneous benefits in addition to daily indemnity.

7. Maternity benefits, if any, must cover pregnancies commencing while the policy is in force if such pregnancies terminate while the policy is in force, except that a probationary period of thirty days may apply to the commencement of a pregnancy.

E. Major Medical Polices

1. Major medical policies may be written with maximum aggregate benefits, coinsurance, deductibles, and internal maximums. These provisions may be utilized together provided the applicable provisions are made clear and the resulting language does not have the tendency to mislead or deceive the policyholder.

2. There shall be no provision terminating benefits for an existing claim upon termination of the policy, unless an extension is granted for the balance of the current benefit period named in the policy, but such extension need not exceed twelve months. The insurer may require that the insured be continually totally disabled during such extension.

3. The benefit period of the policy and the maximum amount payable during the benefit period must be such that the maximum could reasonably be expected to be incurred during the benefit period.

4. If the policy covers complications incident to pregnancy the requirements in regard to extension of maternity benefits shall not be applicable thereto, except for existing claims as set forth in paragraph III-E-2 above.

5. Major medical policies that are subject to Section 164-2(B)(3) may provide for conversion either to the minimum statutory policy or better. The family major medical policy must either specify the benefits to be provided, or it must specify that the converted policy shall be on the form then being issued by the company for conversions from that policy and approved for this purpose by the Superintendent of Insurance.

6. Where a benefit period under a major medical policy commences with the incurrence of the first charge used to satisfy a deductible, and under the policy terms no further benefits can become payable for the same cause after the termination of such period (even by a reapplication of the deductible), the policy will not be permitted to end the benefit period earlier than nine months after the deductible is satisfied. This paragraph has no application where the benefit period is determined by a calendar date rather than by the date of the incurrence of an expense (i.e. it does not apply to calendar year or similar plans).

IV. RIDERS AND ENDORSEMENTS

(As used in these guidelines, a rider is an instrument signed by one or more officers of the insurer to be attached to and form a part of the policy. An endorsement differs from a rider only in that it is applied to a policy by means of printing or stamping on the body of the policy. An endorsement need not be signed or dated if it is included at the date of issue.)

1. When appropriate, riders should indicate that the terms, conditions and exclusions in the policy apply to the riders except those which are specifically inapplicable.

2. Any rider or endorsement which reduces or eliminates coverage in the policy must have signed acceptance by the insured except in the case of an endorsement which is used only at the time of issue of a policy.

3. Impairment riders or endorsements must always have signed acceptance by the insured and must be accompanied by a list of inserts indicating fill-in language. Such language must be specific, confined to specific diseases or areas afflicted and be based upon objective information regarding physical condition.

4. All riders and endorsements must have a form number in the lower left-hand corner, except that "flag endorsements" which merely give directions or call attention to provisions in the policy require only identification of the "flag endorsement" by a form number in the filing but may be used on the policy without such form number.

5. Transfer riders reducing or eliminating waiting periods or the Time Limit on Certain Defenses can be approved for an exchange of policies within a company or between affiliated companies but not for transfer from another company.

6. Riders providing a benefit for which a specific premium is charged should either list the premium on the face of the rider or state that it is included in the premium shown on the face of the policy. The rider can either set forth the amount of premium increase or decrease, or can set forth the new premium for the policy.

V. SPECIAL RULES FOR CONVERSION POLICIES UNDER SECTION 162-5 OR 164-2(B)(3)

1. Policies converted from family policies may exclude any condition excluded by the family policy for such person at the time of the termination of his insurance thereunder. The individual converted policy shall not exclude any other pre-existing conditions. The individual converted policy need not provide maternity benefits.

2. Policies converted from group insurance may exclude Veteran's Hospitals, Workmen's Compensation or benefits under any law, war and Military Service and residence in a foreign country as well as any condition excluded by the group policy. Such policies need not contain maternity benefits, but may not exclude any other pre-existing condition.

3. Insofar as the standard provision Time Limit on Certain Defenses is concerned, the converted policy must be appropriately modified to grant persons entitled to conversion the coverage for pre-existing conditions required by Section 162-5 or 164-2(B)(3) as applicable.

4. Policies converted from group insurance shall not contain an age limit.

5. Policies converted from group insurance may exclude losses covered by Workmen's Compensation but not other occupational injuries, and the miscellaneous hospital benefits must include anesthesia and all medical services except services of doctors and special nurses. Such medical services must be provided in the event of emergency treatment or surgery without the requirement for hospital confinement.

6. Group conversion policies must provide plans I, II, and III, at the option of the insured, with the exception that (a) if any benefit under the group contract is less than the statutory benefit, that particular benefit in the conversion policy may be reduced so that it is not in excess of the same benefit in the group contract, and (b) the deductible plans authorized by Section 162-5 as amended by Chapter 475, Laws of 1962, may be provided in lieu of plans II and III.

7. Applications for conversion policies may not contain questions as to the health of the person or persons entitled to conversion.

8. The minimum term for policies used as conversion from family policies is five years without any cancellation provision, provided that any such term need not extend beyond the age limit, date or period for adults in the policy from which conversion is made.

GUIDELINES

FOR EXAMINATION OF

GROUP ACCIDENT AND HEALTH FORMS

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I. POLICIES

A. General Rules

1. All submissions must comply with the filing rules promulgated by Department Letter of March 3, 1953 as amended.

2. A form in which the printed text has been changed by crossing out or striking out, except for the effecting of simple administrative alternatives, or except in the case of policies where changes are authorized by an approved rider or endorsement, and an appropriate flag endorsement is added, will not be approved.

3. Brief descriptions or titles, if used, should be a reasonably accurate description of the general nature of the policy.

4. Incorporation by reference is governed by Section 142(1). References to other sources to determine factual situations, such as the facts of employee status, membership in a collective bargaining unit or a union, other benefits, salary, termination of employment or membership, etc., are not incorporations by reference. Where sources outside the group policy are referred to for such data as the plan of benefits expressed in a collective bargaining agreement or trust instrument, etc., such source documents or sufficient excerpts therefrom should, for information purposes, accompany the filing, as part of the file.

B. Benefits

1. No group policy may predicate benefits on loss due to "violent and external means". Furthermore, "accidental means" may not be used unless assurance is given the Department that this term will be interpreted in New York in accordance with applicable case law including Burr v. Commercial Travelers, 295 N.Y. 294 (1946).

2. Dependents' loss of time benefits are not approvable.

3. Accidental death and dismemberment benefits should not be in lieu of any other benefit except that dismemberment benefits may be in lieu of loss of time benefits where such dismemberment benefits are equal to or greater than the loss of time benefits.

4. No group policy shall contain a provision for the automatic termination of an individual's coverage upon the happening of any loss except a loss which has exhausted all possible benefits under the policy.

5. If the policy contains an exclusion for injuries or death as a result of self-destruction or self-inflicted injury, such exclusion shall be limited to intentional self-destruction or intentionally self-inflicted injury; however, an exclusion for death or disability as a result of suicide, or any attempt thereat, while sane or insane, or disability as a result of self-inflicted injury while insane, is approvable.

6. Not less than ninety days should be allowed for the happening of specified accidental death and dismemberment losses subsequent to the date of the accident. There should be no qualification that the losses occur while the coverage is in force.

7. Upon termination of insurance whether due to termination of employment, termination of eligibility or termination of the policy, an extension of employee or member basic hospital and surgical benefits (other than for maternity) shall be granted during total disability for hospital confinements commencing or surgery performed during the next thirty-one days for the injury or sickness causing the total disability.

8. If pregnancy benefits are granted, all pregnancies originating during the term of any individual coverage must be covered, and an extension subsequent to termination of coverage must be provided where required by and in accordance with Department Circular Letters of January 23, 1940 and May 3, 1941. The foregoing applies to termination of insurance by reason of termination of employment or termination of the group policy. However, where transfer of coverage is made from an Article IX-C corporation's plan under which no such automatic extension of pregnancy benefits is afforded and immediate pregnancy benefits are afforded under the group policy, then no extension of coverage need be provided in the event of termination of the group policy during the first three years of the policy.

9. Loss of time benefits conditioned upon hospital confinement or surgery shall be considered as hospital or surgical expense benefits for purposes of Section 162-5.

10. Different maximum daily benefits should not be provided because of the kind or type of hospital accommodations, except to permit different maximum daily benefits carried over upon transfer of coverage from existing Article IX-C plans.

11. Surgical schedules may not contain internal catch-all provisions which would include major operations unless the amount payable for such catch-all is at least equal to the maximum allowed under the general surgical catch-all.

12. Where a surgical schedule purports to pay definite amounts, either by specifying the amounts or by indicating units which are to be multiplied by a dollar amount, the certificate benefit provision may not provide that a percentage less than 100% of such amounts will be paid. This rule is not intended to prevent the use of coinsurance, deductible or expense incurred provisions.

13. Where the maximum medical benefit in other than major medical coverages is $1000 or greater, the benefit period should not be less than one year or there should be coverage for expenses commencing within twenty-six weeks of the beginning of the disability. Any other benefit period should bear a reasonable relationship to the amount payable.

14. A policy which provides benefits for any service within the lawful scope of practice of a duly licensed podiatrist or optometrist shall not by its terms deny benefits in the event this service is performed by a podiatrist or optometrist.

C. Major Medical

1. In the event of termination of insurance, because of termination of active employment, a reasonable extended benefit should be provided during total disability, with respect to the sickness or injury which caused the disability, of at least twelve months subsequent to termination of insurance unless coverage is afforded for the total disability under another group plan.

D. Renewal and Cancellation

1. A policy may not contain a provision permitting cancellation during any period for which a premium has been paid.

2. All conditions for non-renewal or termination of the group policy should be fully set forth. The giving of notice of at least thirty days may be used as a condition for such non-renewal or termination.

E. Termination

1. No termination of basic hospital or basic loss of time coverage shall prejudice the right to a claim for benefits which arose prior thereto.

F. Non-Duplication of Coverage Provisions

1. Non-duplication provisions in group contracts may include service-type plans, group and blanket insurance, self- or non-insured plans, franchise plans, group salary continuance programs, and state or federal programs. Life, annuity or pension benefits may not be offset.

G. Coverage of Dependents

1. Coverage of dependents is conditioned upon the employee or union member being covered under the policy, except dependents coverage may be continued in certain circumstances such as death of the employee or union member, entry of the employee or union member into military service, etc.

H. Conditions of Eligibility

1. Under Subdivision 1 of Section 204, the persons eligible for insurance shall be those employees or union members of all or any class or classes determined by conditions pertaining to their employment as illustrated by the following examples; geographic situs of employment, compensation for employment, hours of employment, and occupational duties.

II. CERTIFICATES AND RIDERS

1. Certificates must contain certifying language.

2. Except for riders by which the insurer exercises a specifically reserved right under the policy or which concern only administrative changes, all riders which may be added to the master policy after date of issue and which reduce or eliminate coverage in the policy should provide for signed acceptance by the policyholder.

III. APPLICATIONS

1. Questions requiring applicant's opinion regarding past or present health of a person proposed for coverage should be asked to the best of the applicant's knowledge and belief.

2. Questions regarding an applicant's past or present health which are phrased so as to require factual information rather than a statement of the applicant's opinion need not be so qualified.

3. Under the phrase "with or without medical examination" in Section 221, impaired lives may be excluded from group coverage.