

May 16, 1969

SUBJECT: INSURANCE

Circular Letter 3 (1969)

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

#### GUIDELINES FOR CONDITIONAL RECEIPTS

The problem of defining when and under what circumstances insurance coverage becomes effective under conditional receipts issued in conjunction with life insurance and accident and health insurance policies has long been of concern to this Department. In an effort to resolve this problem, the Department is setting forth the attached guidelines applicable to conditional receipts. These guidelines are to be added as a new Section VI to the existing "Guidelines for Examination of Individual Life Policies and Related Forms" and the "Guidelines for Examination of Individual Accident and Health Forms", issued in Circular Letter 4(1963) on September 20, 1963.

Recognizing each insurer's desire to specify the extent of its liability under its own conditional receipt, the guidelines are intended to provide minimum requirements for "insurability" type conditional receipts. "Approval" type conditional receipts are generally unacceptable in New York State, but conditional receipts providing interim or temporary coverage are considered to be more favorable than the "insurability" type and are thus eligible for approval.

In view of the numerous changes that may be required in the language of conditional receipts now being used by insurers, all licensed insurers now issuing approved conditional receipts in this State may continue to do so, without complying with these guidelines, for a period of one year from the date of this Circular Letter. Those insurers intending to continue the issuance of conditional receipts in New York State after such one year period are requested to submit their conditional receipts for approval prior to the expiration of the one-year period. If an insurer's presently approved conditional receipt complies with the attached guidelines, resubmission of such receipts is not necessary.

Very truly yours,

[SIGNATURE]

Superintendent of Insurance

ATTACHMENT

#### GUIDELINES FOR EXAMINATION OF INDIVIDUAL ACCIDENT AND HEALTH FORMS

##### VI. CONDITIONAL RECEIPTS

###### A. General

1. These guidelines apply only to conditional receipts which require a determination of insurability as a condition precedent to coverage. They do not apply to any other type of receipt or pre-issue practice,

such as those providing interim or temporary coverage without regard to insurability, nor are they intended to require such coverage.

## 2. Definitions

(a) As used in the guidelines, the term "proposed insured" means the person proposed for health insurance and, in the case of policies insuring more than one person, the term "proposed insured" can include all such persons.

(b) Where the guidelines refer to completion of the company's initial application requirements, the phrase shall mean completion of all required parts of the application including completion of the first medical examination, if one is required by the company's underwriting rules. If more than one medical examination is initially required by the company's underwriting rules because of the proposed insured's age or the amount of insurance applied for, completion of the company's initial application requirements shall mean, completion of all required parts of the application including completion of the second medical examination. A statement referring to the company's published initial application requirements must be set forth in the conditional receipt.

(c) For the purpose of the guidelines, any determination of "insurable" and "insurability" shall be made as indicated in Guideline VI-B-2.

3. The guidelines do not preclude conditional receipts which, in the opinion of the Superintendent, are more favorable to the proposed insured than as described herein. For example, these include but are not limited to:

(a) Receipts which do not require that the amount paid be equal to the full first premium for the policy applied for.

(b) Receipts which permit coverage if the proposed insured is insurable on either a standard or a sub-standard basis.

4. The guidelines are intended to be a statement of certain general principles applicable to conditional receipts rather than a statement of all the provisions that may be included in such receipts or a statement of the precise wording to be used in such receipts.

## B. Guidelines

### 1. A conditional receipt must include an agreement

(a) to provide coverage subject to any limit regarding the amount of insurance specified in the receipt, contingent upon insurability as a condition precedent, and

(b) to provide that such insurability be determined as of a date no later than the date upon which the company's initial application requirements have been completed and the required premium has been paid.

2. A determination of insurability means a determination by the company as to whether the proposed insured is insurable under its underwriting rules and practices for the plan and amount of insurance applied for and at the company's standard premium rate.

3. If the proposed insured is insurable as of the date provided for in Guideline VI-B-1 coverage must begin not later than such date, except as provided in Guideline VI-B-5.
4. Although the proposed insured dies or undergoes a change in health after the date provided for in Guideline VI-B-1 but before the application is approved or rejected, and before the expiration of any time limit specified in the receipt, a company may determine that the proposed insured is not insurable only as of the date specified in Guideline VI-B-1.
5. A company may honor a written request from the applicant that coverage is to commence as of a specified date later than the date provided for in Guideline VI-B-1.
6. In mail order cases and in all cases where a premium is paid in advance and certain participation requirements must be met, it is permissible for the company to postpone the effective date of coverage to the date of issuance of the policy.