

**PRODUCT OUTLINE**  
**INDIVIDUAL ACCIDENT INSURANCE**  
As of 1/30/04

Table of Contents

I. Key References .....	1
II. Cover Page .....	1
III. Policy Schedule Page.....	2
IV. Table of Contents must be included when required by Section 3102 (c)(1)(G). .....	2
V. Mandatory Standard Contract Provisions .....	2
VI. Optional Standard Provisions .....	4
VII. Permissible Exclusions and Limitations on Coverage.....	5
VIII. Regulatory Rules relating to the Content of Forms for Individual Insurance.....	6
IX. Other Provisions .....	7
X. Applications .....	14
XI. Disclosure Requirements .....	16
XII. Marketing of Individual Accident Insurance Using Group Methods.....	16
XIII. Conditional Receipts/Interim Insurance Agreements .....	19
XIV. Rating Procedures and Requirements .....	20

## I. Key References

Key Insurance Law Sections – 3102, 3105, 3201 (Form Approval issues), 3216 especially 3216 (d)(1)(2) (standard provisions), 3204 (contract/application issues).

Key Applicable Regulations – Regulation 62 (11 NYCRR 52) minimum standards for form, content and sale of health insurance including Sections 52.2, 52.9, 52.16, 52.17, 52.31, 52.33, 52.40, 52.41, 52.43, 52.45 (minimum loss ratio standards), 52.51 (applications), 52.53 (conditional receipts/interim insurance agreements), 52.54 and 52.61 (disclosure requirements), Regulation 169 (11 NYCRR 420) privacy of consumer financial and health information including Section 420.18.

Key Circular Letters – Circular Letter No. 12 (1991) – for issues relating to accident insurance written as part of travel insurance;

## II. Cover Page

1. Company's Name and Address (New York State licensed entity).
2. Full street address of the company's home office in prominent place (generally front and back of policy form) for disclosure purposes.
3. No unlicensed entity in New York State should appear on the form. – Section 3201 (c)(1).
4. Include name of product on the form within the defined category of Section 52.9 of Regulation 62.
5. Include "free look" provision within parameters of Section 3216 (c)(10). Please note exception for single premium nonrenewable policies insuring against accidents only or accidental bodily injuries only.
6. The age limit or date or period, if any, after which the coverage provided by the policy will not be effective or the age limit, date or period after which the policy may not be renewed is stated in a renewal provision set forth on the first page of the policy or as a separate provision bearing an appropriate caption on the first page of the policy or in a brief description in not less than fourteen point bold face type set forth on the first page of the policy. – Section 3216(c)(11)
7. Form identification number in lower left-hand corner of form – Section 52.31 (d).
8. Renewability provisions of form to be placed on the front page of the policy form – Section 52.17 (a)(1)(2).
9. If renewability provisions are "noncancellable" and/or "guaranteed renewable", must comply with Sections 52.17 (a)(5)(6)(7) of Regulation 62. In general for accident insurance forms, the terms "noncancellable" or "noncancellable and guaranteed renewable" can only be used in a form which the insured has the right to continue in force by the timely payment of premiums as set forth in the form until age 65. During this renewal period, the insurer has no right to make unilaterally any change in any provision of the form while the form is in force. When the term "guaranteed renewable" is to be used alone without using the term "noncancellable" in conjunction with the term "guaranteed renewable", the term "guaranteed renewable" may only be used in a form which the insured has the right to continue in force by the timely payment of premiums until age 65. During this renewal period, the insurer has no

right to make unilaterally any change in any provision of the form while the form is in force except the insurer may make changes in premium rates by classes.

An accident insurance form using rates predicated upon a level premium age-at-issue basis must contain renewal provisions which are guaranteed renewable, noncancellable or provide nonrenewal is subject to the consent of the superintendent. This is required so that an insurer does not unjustifiably nonrenew level premium forms to keep reserves based upon a level premium rating methodology - Section 52.40(b)(1)

Section 3216(f) requires that coverage be provided for any time period the insurer accepts premium. Sometimes an accident policy sets an age limit after which there is no coverage. If the insurer has accepted premium for a time period during which the insured reaches the policy age limit for benefits, coverage must be provided to the end of the time period. The insurer needs to take affirmative action in ascertaining whether a person will reach a policy age limit for termination of benefits to determine whether premium should be accepted.

10. Signature of Officer(s) – signature of one or more company officers should appear on the face page to execute the contract on behalf of the company

### III. Policy Schedule Page

1. Complete with hypothetical data – Section 52.31 (f).
2. Premium summary amounts and provisions dealing with insured participation status in surplus or dividends should appear – originates from Section 52.31 (f) and Section 3216 (c)(1).
3. Principal sum amounts, daily benefit amounts, monthly benefit amounts and similar optional choices made by the insured should be set forth – originates from Section 52.31 (f) and Section 3204 (a)(1).
4. Name of insured and covered family members spaces – originates from Section 52.31 (f) and Section 3216 (c)(3).
5. Spaces for effective date of insurance, renewal dates and renewal terms – originates from Section 52.31 (f) and Section 3216 (c)(2).
6. Optional choices of insured regarding certain benefits and/or riders should be set forth – originates from Section 52.31(f) and Sections 3204(a)(1).

### IV. Table of Contents must be included when required by Section 3102 (c)(1)(G).

### V. Mandatory Standard Contract Provisions

1. Must include “Entire Contract; Changes” provision with no incorporation by reference to writings not part of the form – Section 3216 (d)(1)(A), Section 3204(a)(1).
2. Must include “Time Limit on Certain Defenses” provision in accordance with statutory options. Section 3216 (d)(1)(B)(i) allows the insurer to have two options regarding application misstatements for an individual accident policy and the ability of the insurer to void the policy or deny a claim due to misstatements. The first option allows the insurer to void the policy or deny a claim for loss incurred or disability commencing within the first two years of the policy issuance date on the basis of application misstatements. For fraudulent misstatements in the application, there is no two-year time limit on the ability of the insurer to void the policy or deny a claim for loss incurred or disability commencing from the date of

policy issuance. The second option is available only for a policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue. This second option would be available to individual accident insurers which issue “noncancellable” or “guaranteed renewable” policies within the meaning of Sections 52.17 (a)(5)(6)(7) of Regulation 62. This second option requires the insurer to label this option as “Incontestable” and not “Time Limit on Certain Defenses”. This option indicates that, once the policy has been in force for two years during the lifetime of the insured, the policy is incontestable as to any statements contained in the application. At the insurer’s option, the insurer may add a statutory phrase extending the calculation of the two-year period by any period of disability of the insured.

Insurers are reminded these are two distinct statutory options, and the most favorable aspects for an insurer cannot be made into a third option not sanctioned by statute. For example, the fraudulent misstatement exception of the first option cannot be added to the second option.– Section 3216 (d)(1)(B).

May include a preexisting condition time period complying with Section 3216(d)(1)(B)(ii) when the accident policy benefits warrant a pre-existing condition time period. The Department will view a pre-existing condition time period as appropriate in an accident only policy when the type of accident coverage provided can lead to factual circumstances where pre-existing conditions trigger benefits. Accident only policies which provide coverage for risks where pre-existing conditions are irrelevant (e.g., – dismemberment of a limb) would not be appropriate coverage for a pre-existing condition time period. (Section 3201(c)(3)).

Section 3216(d)(1)(B)(ii) sets a two-year time period from the coverage issuance date for an accident insurer to exclude coverage for preexisting conditions. For accident insurance coverage, it is important to note that Section 52.2(v) defines a preexisting condition as the existence of symptoms which would ordinarily cause a prudent person to seek diagnosis, care or treatment within a two-year period preceding the effective date of coverage or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a two-year period preceding the effective date of coverage.

Section 3216(d)(1)(B)(ii) indicates that if a disability commences after two years from the coverage issuance date, that disability is not subject to a preexisting condition limitation. Losses arising from accidents unrelated to disability definitions (e.g. – benefits such as hospital indemnity benefits or non-disabling injury indemnity benefits) have preexisting condition time periods measured from the coverage issuance date, but such losses which occur on a continuous basis during the first two years of coverage must be covered on the 731<sup>st</sup> day from the coverage issuance date (i.e. – “loss incurred” wording of Section 3216 (d)(1)(B)(ii).

Please note Section 52.17(a)(27) of Regulation 62 limitations for a 12 month pre-existing condition time period where the application is “guaranteed issue”. (see discussion in this outline for shorter pre-existing condition time limits when accident coverage is short term in nature.)

Conditions of an insured not considered preexisting conditions within the meaning of Section 52.2(v) are not subject to any preexisting condition limitation. In that instance these conditions would be considered “first manifested” or “first diagnosed or treated” after the coverage issuance date.

3. Must include “Grace Period” provision for premium payment in accordance with statutory options – Section 3216 (d)(1)(C).

4. Must include “Reinstatement” provision in case of form lapse in accordance with statutory options. Section 3216 (d)(1)(D) of the Insurance Law makes reference to a conditional receipt when premium is tendered with an application for reinstatement. Insurers are reminded that the conditional receipt used for reinstatement of individual accident insurance forms has its own statutory requirements for use in the reinstatement situation. For example, Section 3216 (d)(1)(D) of the Insurance Law places a maximum 45-day time limit following the date of the conditional receipt for insurer action on a reinstatement application where the insurer or its agent issued a conditional receipt for premium tendered. The form is reinstated on the 45<sup>th</sup> day following the conditional receipt date if the insurer has not approved or disapproved the reinstatement application in writing within that time period. - Section 3216 (d)(1)(D).
5. Must include “Notice of Claim” provision in accordance with statutory options – Section 3216 (d)(1)(E).
6. Must include “Claim Forms” provision – Section 3216 (d)(1)(F).
7. Must include “Proofs of Loss” provision – Section 3216 (d)(1)(G).
8. Must include “Time of Payment of Claims” provision in accordance with statutory options – Section 3216 (d)(1)(H).
9. Must include “Payment of Claims” provision in accordance with statutory options – Section 3216 (d)(1)(I).  
  
Section 3216 (d)(1)(I) contains several scenarios and/or options for the insurer. Each scenario and/or option chosen must be as favorable or more favorable than Section 3216 (d)(1)(I).
10. Must include “Physical Examinations and Autopsy” provision – Section 3216 (d)(1)(J).
11. Must include “Legal Actions” provision – Section 3216 (d)(1)(K).
12. When applicable, must include “Change of Beneficiary” provision in accordance with statutory options – Section 3216 (d)(1)(L).

## VI. Optional Standard Provisions

1. If insurer chooses to place a “Change of Occupation” provision in the coverage, must comply with Section 3216(d)(2)(A).
2. If insurer chooses to place a “Misstatement of Age” provision in the coverage, must comply with Section 3216 (d)(2)(B).
3. If insurer chooses to place an “Other Insurance in this Insurer” provision in the coverage, must comply with Section 3216 (d)(2)(C).
4. If insurer chooses to place an “Insurance with Other Insurers” provision in the coverage, must comply with Section 3216 (d)(2)(E).
5. If insurer chooses to place a “Relations of Earnings to Insurance” provision in the coverage, must comply with Section 3216 (d)(2)(F). (Applicable to any accident only disability income benefits)

6. If insurer chooses to place an “Unpaid Premium” provision in the coverage, must comply with Section 3216 (d)(2)(G).
7. If insurer chooses to place a “Cancellation” provision in the coverage, must comply with Section 3216 (d)(2)(H).
8. If insurer chooses to place a “Conformity with State Statutes” provision in the coverage, must comply with Section 3216 (d)(2)(I).
9. If insurer chooses to place an “Illegal Occupation” provision in the coverage, must comply with Section 3216 (d)(2)(J). See also Section 52.16 (c)(4)(i) of Regulation 62.
10. If insurer chooses to place an “Intoxicants and Narcotics” provision in the coverage, must comply with Section 3216 (d)(2)(K).

## VII. Permissible Exclusions and Limitations on Coverage\*

1. If insurer appropriately places (see V., 2 above) a preexisting condition limitation in the coverage, must comply with Sections 52.16 (c)(1) and 52.2(v) of Regulation 62 and Section 3216 (d)(1)(B)(ii) of the Insurance Law.
2. If insurer chooses to place an exclusion or limitation on coverage for mental or emotional disorders, alcoholism or drug addiction must comply with Section 52.16 (c)(2) of Regulation 62 and Section 3216 (d)(2)(K) as pertinent.
3. If insurer chooses to place an exclusion or limitation on coverage for war or act of war, suicide, attempted suicide or intentionally self-inflicted injuries, must comply with Section 52.16 (c)(4) of Regulation 62.

If insurer chooses to place an exclusion or limitation on coverage for participation in a felony, riot or insurrection, service in the armed forces or units auxiliary thereto, aviation (other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline), must comply with Section 52.16 (c)(4). For felony participation, see also Section 3216 (d)(2)(J) of the Insurance Law. For service in the armed forces, insurer must also include a “suspension” provision complying with Sections 3216 (c)(13)(14) and Section 52.17 (a)(9).

4. If insurer chooses to place an exclusion or limitation on coverage for cosmetic surgery, must comply with Section 52.16 (c)(5) of Regulation 62. (Applicable to accident medical expense benefits)
5. If insurer chooses to place an exclusion or limitation on coverage for foot care, must comply with Section 52.16 (c)(6) of Regulation 62. (Applicable to accident medical expense benefits)
6. If insurer chooses to place an exclusion or limitation on coverage for care in connection with structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference must comply with Section 52.16 (c)(7) of Regulation 62.
7. If insurer chooses to place an exclusion or limitation on coverage for benefits provided by the government, benefits provided pursuant to certain laws, services provided by certain employees or family members or for services normally provided free of charge, must comply with Section 52.16 (c)(8) of Regulation 62. (Some of these exclusions may be relevant for particular types of accident benefits such as accident medical expense, accident disability income or others)

8. If insurer chooses to place an exclusion or limitation on coverage for dental care or treatment, must comply with Section 52.16 (c)(9) of Regulation 62.
9. If insurer chooses to place an exclusion or limitation on coverage for eyeglasses, hearing aids, and exams for their prescription or fitting, must comply with Section 52.16 (c)(10) of Regulation 62. (Applicable to accident medical expense benefits)
10. If insurer chooses to place an exclusion or limitation on coverage for rest cures, custodial care and transportation, must comply with Section 52.16 (c)(11) of Regulation 62.
11. If insurer chooses to place an exclusion or limitation on coverage related to territorial restrictions, must comply with Section 52.16 (c)(12) of Regulation 62.

For Section 52.16 (c)(12) compliance, must provide coverage within the United States, its possessions and the countries of Canada and Mexico.

12. For compliance with Sections 52.16 (e)(2) and 52.2 (i) of Regulation 62, insurers should note that Regulation 62 recognizes only aviation and its related activities and participation as a professional in sports as extra-hazardous activities which can be initially underwritten. These extra-hazardous activities may be excluded from coverage by means of prominently disclosed waivers (see Section 52.16 (e)(2)) at coverage issuance or extra premium (“rate up”) may be charged for coverage of such extra-hazardous activities or standard coverage may be issued when an applicant indicates participation in such extra-hazardous activities or coverage may be declined based upon participation in such extra-hazardous activities. Sections 52.16 (e)(2) and 52.2 (i) do not recognize any other avocations, vocations or activities as extra hazardous. Therefore, the insurer may only issue standard coverage or decline coverage for applicants participating in avocations, vocations or activities other than those defined in Section 52.2(i).
13. Individual accident and health coverages, including accident insurance, are not plans which can contain coordination of benefit provisions (Section 52.23 (e)(3)(i)). Insurers have the ability to financially underwrite for other coverage before issuance, and have statutory provisions (Sections 3216 (d)(2)(C), (D), (E) and (F)) for excess insurance situations after issuance.

\*In general, the exclusionary or limiting language can be no less favorable than the various paragraphs of Section 52.16(c) of Regulation 62.

### VIII. Regulatory Rules relating to the Content of Forms for Individual Insurance

1. If insurer reduces benefits due to an age limit attainment, including a benefit period reduction, such reduction must be referenced on the first page or specification page of the policy – Section 52.17 (a)(3) of Regulation 62.
2. Accident benefits cannot be predicated upon loss occurring through accidental means or violent and external means – Section 52.17 (a)(8) of Regulation 62.
3. Insurer must comply with Section 52.17 (a)(9) of Regulation 62 and Section 3216 (c)(13)(14) of the Insurance Law for insureds entitled to suspend coverage during periods of military service.
4. Insurer attaching any rider or endorsement which reduces or eliminates coverage after policy issuance shall provide for signed acceptance by the insured – Section 52.17 (a)(12) of Regulation 62. See also 52.16 (e)(2), however, for waivers issued as a condition of issuance, renewal or reinstatement.

5. Riders or endorsements providing a benefit for which a specific premium is charged shall show the premium on the application, rider or elsewhere in the form – Section 52.17 (a)(14) of Regulation 62.
6. In general, the form cannot require loss from accidental injury to commence within less than 30 days after the date of an accident – Section 52.17 (a)(26) of Regulation 62.
7. In general, any form which the insurer may cancel or refuse to renew cannot require that the form be in force at the time loss commences if the accident occurred while the form was in force – Section 52.17 (a)(26) of Regulation 62.
8. Forms based upon attained age shall include the applicable schedule of rates – Section 52.17 (a)(29) of Regulation 62.
9. Accident insurance forms which contain accidental death and dismemberment (AD&D) benefits shall have the AD&D benefits payable if the loss occurs within 90 days from the date of the accident, irrespective of total disability - Section 52.17 (b)(1) of Regulation 62.
10. Accident insurance forms which contain specific accident dismemberment benefits shall not have the specific accident dismemberment benefits payable in lieu of other benefits unless the specific benefit exceeds the other benefit – Section 52.17 (b)(3) of Regulation 62.
11. Filing of accident policies to be sold by vending machine shall be accompanied by information describing the operation of the machine. Copy of any information and direction used in connection with the machine shall be included in the filing.-Section 52.17(b)(2) of Regulation 62
12. Benefits for specific injury due to accident shall not be in lieu of disability benefits, unless the specific benefit exceeds the disability benefit – Section 52.17 (c)(1) of Regulation 62.
13. No accident insurance form shall provide for reduction of benefits prior to age 65 by reason of a change in employment status or the income of the insured except in accordance with Sections 3216 (d)(2)(A) or 3216 (d)(2)(F), whichever is applicable – Section 52.17 (c)(3) of Regulation 62. (Section 3216(d)(2)(F) applicable to accident disability income benefits.)
14. No accident insurance form shall reduce benefits solely on the basis of the sex or marital status of the insured. No individual or entity shall refuse to issue any accident policy or cancel or decline to renew such policy because of the sex or marital status of the applicant or policyholder. (Sections 2607, 4224(b)(1)).
15. Accident disability benefits conditioned upon hospital confinement shall be considered hospital, medical or surgical expense benefits for purposes of renewability and eligibility under Section 3216 of the Insurance Law and any relevant regulations – Section 52.17 (c)(4) of Regulation 62.
16. Accident disability income forms providing disability benefits for dependents shall adequately define the conditions establishing disability – Section 52.17 (c)(5) of Regulation 62.

#### IX. Other Provisions

1. Principal sum (benefit levels) amounts for accidental death and dismemberment benefits must be paid in accordance with Sections 52.9 and 52.1(c) of Regulation 62 and Sections 3201(c)(3) and 3217(b)(5) of the Insurance Law. Principal sum amounts of at least \$500 are generally considered acceptable. The Department allows reasonable differentiation among

principal sum amounts paid for accidental death and dismemberment benefits for the primary insured and dependent spouse (domestic partner) and dependent children (assuming family coverage is provided). Family coverage differentiated principal sum amounts are generally considered acceptable if at least paid at a \$500 level while the level paid for the primary insured is the same or greater. Other family coverage differentiated principal sum amounts (e.g., -- primary insured receives less than dependents or benefits paid at less than a \$500 level) would be considered by the Department in accordance with the above noted regulatory and statutory sections.

2. In the review of individual accident insurance policies, the Department uses the standards in Section 52.1(c) of Regulation 62 and Sections 3201(c)(3) and 3217(b)(5) of the Insurance Law on a regular basis. These standards are applied to the benefit structures of individual accident insurance forms so that such forms provide substantial economic value to the policyholders and are not unjust, unfair, inequitable, misleading, deceptive or contrary to law or the public policy of New York State.

The insurance industry when it writes individual accident coverage often uses various and sundry benefit structures. The Insurance Department encourages the writing of accident coverage so that benefits are paid when accidents occur due to any cause whatsoever (general accident coverage). However, the Department takes note of the fact that the industry writing individual accident coverage often fragments the general accident coverage risk into coverage for only certain types of accidents. The Department will allow such fragmentation only when the resulting coverage in the individual accident policy provides substantial economic value to the policyholders (see above).

As a general matter, the Department considers the writing of general accident coverage together with coverage for only certain types of accidents as a reasonable way to provide meaningful coverage to policyholders and which provides substantial economic benefit. The Department will consider coverage written only for certain types of accidents without general accident coverage (e.g. – travel accident policies) and will approve it when it complies with Section 52.1(c) of Regulation 62 and Sections 3201(c)(3) and 3217 (b)(5) of the Insurance Law. However, accident coverages written only for coverage of accidents while on a bus without general accident coverage, for example, would be reviewed carefully by the Department for compliance with the above noted regulatory and statutory sections. We note, for instance, that an accident insurer could provide general accident coverage of some amount together with coverage of accidents while riding as a fare paying passenger on any scheduled common carrier to broaden the coverage to provide greater economic value to policyholders at little, if any, additional premium cost.

3. The Department will approve benefits for dislocations or fractures arising from injuries due to accidents. For these types of benefits, Sections 3201(c)(3) and 3217(b)(5) of the Insurance Law are relevant as well as Section 52.1(c) of Regulation 62.

In general, the Department will approve benefits for dislocations or fractures when such benefits are paid by identification of principal sum amounts for particular dislocations or fractures or identification of a principal sum amount for any dislocation or fractures. The placement of a schedule in the individual accident policy form listing specific losses, dislocations and fractures involving the human body and applying factors for each particular dislocation or factor to a principal sum amount is another acceptable manner of providing these benefits. Other reasonable payment mechanisms will be entertained by the Department.

The monetary amount payable for such losses must comply with the above noted statutory and regulatory sections. More severe losses covered by the individual accident policy must be covered at levels approximately equal to the full principal sum identified for the primary

insured, dependent spouse (domestic partner) and dependent children (assuming family coverage is provided). Less severe losses covered by the individual accident policy may be covered at levels which are smaller percentages of the full principal sum identified for the primary insured, dependent spouse (domestic partner) and dependent children (assuming family coverage is provided). Other reasonable methods of paying monetary amounts for such losses will be entertained by the Department. The Department encourages that benefits for dislocations and fractures be part of a broader spectrum of accident benefits to comply with the above noted statutory and regulatory sections.

4. The Department will approve hospital indemnity confinement benefits for injuries due to accidents without providing hospital indemnity confinement benefits for sicknesses under Section 52.9 of Regulation 62. While realizing that hospital indemnity confinement benefits do not bear a direct relationship to the amount of charges actually billed for the hospital confinement of an insured, the Department would apply Sections 3201(c)(3) and 3217(b)(5) of the Insurance Law and Section 52.1(c) of Regulation 62 to be certain the accident hospital indemnity confinement benefit paid provides substantial economic benefits to insureds. In general an accident hospital indemnity confinement benefit of at least \$25 per day is considered reasonable. The Department would also allow payment of a “lump sum” amount for accident hospital indemnity confinement benefits in addition to a per day indemnity amount or in lieu of a per day indemnity amount. When the “lump sum” amount is paid in lieu of a per day indemnity amount, the “lump sum” amount should bear some reasonable relationship to payment of a \$25 per day indemnity amount for at least 30 days. Other benefit amounts and durations would be considered by the Department depending upon the particular policy benefit structure, but the foregoing is provided as examples of what the Department routinely finds acceptable. The Department encourages accident hospital indemnity benefits to be part of a broader spectrum of accident benefits to comply with the above noted statutory and regulatory sections.

The Department cautions accident insurers against attempting to combine accident indemnity hospital, medical or surgical benefits with sickness riders or sickness benefits of any type. True individual accident insurance is exempt from open enrollment and community rating requirements in New York State due to Section 360.2(c) of Regulation 145 (11 NYCRR 360). However, attempts by insurers to offer sickness benefits with accident benefits on a mandatory or voluntary basis may make a particular coverage akin to basic hospital insurance under Section 52.5 of Regulation 62 or basic medical insurance under Section 52.6 of Regulation 62. Products submitted to the Insurance Department as accident insurance which can be combined with sickness benefits to reach levels under Sections 52.5 or 52.6 will trigger open enrollment and community rating (and mandates and all requirements of hospital, medical, surgical expense incurred coverages) due to Section 360.2(c) of Regulation 145.

The Department also reminds accident insurers of the existence of Section 3216(l) of the Insurance Law. In essence, this statutory section proscribes the sale of individual major medical, comprehensive or other comparable individual contracts unless those individual contracts meet the requirements for open enrolled and community rated individual standardized coverages under Section 4322 of the Insurance Law. Accident insurers attempting to combine accident indemnity hospital, medical or surgical benefits with sickness riders or sickness benefits of any type may be attempting to sell major medical, comprehensive or other comparable individual contracts within the meaning of Section 3216(l). The Department would review individual accident coverage submissions which can be sold with sickness benefits with a view toward ascertaining whether Section 3216(l) is relevant. If Section 3216(l) is a factor, the accident submission would be held to the

standards of Section 4322 of the Insurance Law and no longer treated as an accident insurance only submission.

5. Accident insurers are reminded of the existence of specified disease insurance as a separate category of insurance in New York State (please see Section 52.15 of Regulation 62 and the specified disease outline and check list). Accident insurers cannot add coverage for specified diseases to accident coverage because adding specified disease benefits to unrelated accident coverage gives the impression to a consumer that the specified disease benefits are more comprehensive than is actually the case. Section 52.15(a) defines specified coverage and that definition does not indicate that accident benefits are part of a specified disease coverage.

Giving the illusion of comprehensive benefits by adding specified disease benefits to accident insurance is contrary to the supplementary nature of specified disease coverage and contravenes Section 3201(c)(3) of the Insurance Law. Section 52.15(b) of Regulation 62 requires a person with limited specified disease coverage to have actual underlying comprehensive coverage in order to purchase limited specified disease coverage. Adding specified disease benefits to accident insurance might convince an insured to lapse his/her actual underlying comprehensive coverage and keep only the accident insurance with “add-on” specified disease benefits. This is contrary to Section 52.1(c) of Regulation 62 and Section 3217(b)(1)(2)(3) of the Insurance Law while adversely affecting the community rated pools of actual comprehensive coverages marketed in New York State.

6. Accident insurers are reminded of the differentiation between accidents and certain types of conditions which may result from accidents and are more properly considered as specified diseases.

The category of accident insurance in Section 52.9 of Regulation 62 should not be used as a way to evade the requirements of specified disease coverage found in Section 52.15 of Regulation 62. For examples, at times insurers place benefits for comas and paralysis in accident policies. At other times benefits for comas and paralysis are placed in specified disease policies treating those conditions as diseases.

Section 3217(b)(1)(2)(3)(4)(5) of the Insurance Law enables the Department to promulgate minimum standards regulations for certain purposes. Some of the chief purposes stated in that statutory section are: 1) reasonable standardization and simplification of coverages to facilitate understanding and comparisons, 2) elimination of provisions which may be misleading or unreasonably confusing, in connection either with the purchase of such policies or contracts or with the settlement of claims, and 3) elimination of deceptive practices in connection with the sale of such policies or contracts. Pursuant to such statutory authority, the Insurance Department has promulgated two distinct categories in Regulation 62 dealing with accident insurance (Section 52.9) and specified disease coverage (Section 52.15).

Using comas and paralysis as examples, it appears both are conditions treated like distinct diseases or conditions when coma and paralysis are present for the long term. For instance, comas and paralysis can be life threatening in nature and cause a person to incur substantial financial out-of-pocket expenses for their long term treatment whether caused by a car accident or a cerebral hemorrhage unrelated to any accident at all. Thus the conditions tend to be distinct.

Based upon the above, the Department views the conditions of coma and paralysis as properly within the category of specified disease. Placement of these conditions within a specific minimum standards category of Regulation 62 is done to implement the statutory purposes noted above. Treatment of these conditions as specified diseases will not allow insurers to evade the requirements of Regulation 62 for specified disease coverage, and it will

not allow insurers to move these conditions from one category of Regulation 62 to another causing market place confusion.

To date, the Department has recognized a minor exception to the above for the condition of paralysis. In order to broaden the concept of dismemberment of a limb for which benefits are paid in an accident policy, the Department has permitted accident insurers (which desire to do so) to include the condition of paralysis of a limb (sometimes referred to as loss of use) as a triggering event resulting in payment of accident policy dismemberment benefits. This minor exception expands the events which will result in dismemberment benefits payment beyond the actual loss of limbs, and it tends to make this narrow dismemberment benefit somewhat broader in scope for an insured (at little, if any, added premium) without allowing insurers to largely evade the requirements for specified disease coverage found in Section 52.15 of Regulation 62.

7. In accordance with Section 52.17(a)(16) of Regulation 62, accident hospital indemnity confinement benefits may be paid at a higher rate when an insured is assigned to a different level of care unit (e.g. – intensive care or extended care). In general, some increased daily rate is paid when an insured is assigned to a different level of care, and that increased daily rate is a multiple of the daily rate paid for a more usual and common level of care.
8. The Department will approve an ambulance benefit as part of an individual accident policy which provides a meaningful benefit (generally at least \$50 for one ambulance service use). Ambulance benefits may be limited to transfers to or from a hospital and need not cover transfers to outpatient facilities although such transfers to outpatient facilities would be approved. Increased benefits for specialized types of ambulance usage (e.g. – air ambulance) are approvable by the Department.
9. In general, the Department will approve ancillary or incidental benefits covering certain medical or surgical benefits due to accident as part of an accident insurance policy. Such benefits (such as physician treatment, x-rays, emergency room treatments) should be paid on an indemnity basis and at levels not approaching the levels set forth in Sections 52.5 and 52.6 of Regulation 62. Once these types of ancillary or incidental indemnity benefits approach the levels of Section 52.5 and 52.6 (or are paid on an expense incurred basis approaching the levels of Sections 52.5 or 52.6), these benefits may trigger the provision of certain services mandated by statute found in Section 3216(i)(j) of the Insurance Law, and accident insurers generally do not want to provide these mandated coverages in an accident insurance policy.
10. Accident insurance policies providing a disability income benefit due to accident only are approvable by the Department. We refer accident insurers to the disability income product outline and check list for the requirements pertaining to this type of benefit.
11. Form definitions of “hospital” as used in an accident insurance policy form must comply with Section 52.2(m) of Regulation 62.
12. Form definitions of “injuries”, “pre-existing condition”, “first manifest”, “first diagnosed or treated” or similar terminology must be meaningful as used in an accident insurance form, fair to the consumer and fully disclosed in the form language – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d), 52.2(v) and 52.9 of Regulation 62.
13. Form definition of “physician” or any substitute terms cannot unduly limit access of the insured to benefits under the accident insurance form – originates from Section 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.9 of Regulation 62.

14. Form provisions dealing with waiver of premium resulting from injuries or form provisions dealing with assignment of benefits must be meaningful as used in an accident insurance form, fair to the consumer and fully disclosed in the form language – originates from Section 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d), 52.9 and 52.16(b) of Regulation 62.
15. Section 3216(d)(1)(K) is governed by “lead in” wording present in Section 3216(d)(1). The “lead in” wording proscribes approval of language which would be less favorable in any respect to an insured than the wording in Section 3216(d)(1)(K). Section 3216(d)(1)(K) sets forth parameters to allow an insured to bring an action at law or equity in an accident insurance policy or any individual commercial accident and health insurance policy. Arbitration provisions set forth as a contractual right of an insurer generally preclude an insured from bringing an action at law or equity. Therefore, the Department is under a statutory constraint because arbitration provisions in a policy which preclude an insured from bringing an action at law or equity would be less favorable in many respects to an insured than the parameters set forth in Section 3216(d)(1)(K).

The Department addresses here its statutory inability to approve arbitration provisions in an accident insurance policy. The Department does not address in this product outline other reasonable and appropriate mechanisms which an insurer may be able to use in its ongoing relationship with an insured.

16. Form provisions providing update increases or future guaranteed option increase dates or events where accident insurance benefits are automatically increased without evidence of good health upon payment of proper premium are approvable in general.

The Department would allow a reasonable number of times for such increases to occur for an appropriate premium.

The Department would allow an insurer to use reasonable methods to protect itself against anti-selection and to encourage insureds to opt for increases without evidence of good health when still relatively healthy. However, limiting an insured to maximum increase amounts based upon undefined issue and participation limits in effect at some future date would make the benefit illusory. The insurer could adversely change its issue and participation limits in the future to limit or eliminate the insured’s ability to increase accident insurance benefits without evidence of good health. An insurer should guarantee its issue and participation limits in effect when the benefit providing increases without evidence of good health is issued so the benefit is not illusory. – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.9 of Regulation 62.

17. Insurers in the individual accident insurance market are reminded of their obligations under Section 3328 of the Insurance Law.

Form provisions which coordinate or integrate accident insurance benefits with benefits payable from other individual or group health or disability policies are not approvable in New York State for use in individual accident insurance forms – Section 52.23(e)(3)(i) of Regulation 62.

18. Individual accident insurance policies may provide for family coverage in accordance with Sections 3216(a)(3), 3216(c)(3), 3216(c)(4) of the Insurance Law and Sections 52.17(a)(30)(31) of Regulation 62.

19. Although not a requirement for insurance against accidental injury only, the Department will approve accident insurance policy provisions providing for a right of conversion to a separate individual accident insurance policy without evidence of insurability when a dependent

covered under a family accident insurance policy is no longer within the definition of family set forth in the family policy. – Section 3216(c)(5)

20. Travel Accident Insurance – This is a particular type of accident insurance often marketed through travel agents to cover accident risks when on a trip. Most often the accident travel insurance is issued for a specific term (usually short in duration) and is non-renewable. On occasion, however, some accident insurers have issued renewable travel accident policies for members of the public who travel frequently (e.g. – business persons). The short term accident travel insurance is geared to members of the public travelling for pleasure or who do not travel as frequently.

This product outline deals solely with those components of travel accident insurance which come within the purview of Section 1113(a)(3) of the Insurance Law. Prevalent types of benefits often provided in travel accident insurance policies coming within the purview of Section 1113(a)(3) are: flight insurance, emergency medical and dental benefits, trip cancellation/interruption benefits, travel accident coverage and repatriation benefits.

21. Flight insurance – Usually this component provides coverage for accidental death and dismemberment benefits while present as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline. See above concerning a discussion of accidental death and dismemberment benefits.

Flight insurance usually is narrow in scope and for short duration thereby raising compliance issues under Sections 3217(b)(5) and 3201(c)(3) of the Insurance Law and Section 52.1(c) of Regulation 62. Often the attainment of minimum loss ratios as set forth in Section 52.45(a) of Regulation 62 are also a concern. In order to expand flight insurance coverage as much as possible to address these concerns, the Department requires that flight insurance coverage be provided not only while riding on a flight, but also when boarding or alighting from a flight. Insurers often add coverages such as common carrier accident coverage while en route to an airport or leaving an airport for a home destination in order to expand the scope of coverage to a meaningful level for the insured.

22. Emergency medical and dental benefits – Usually this component pays for some combination of hospital, surgical and/or dental benefits arising as a result of an emergency during travel. The intent of such benefits is to provide interim coverage until an insured returns home where his/her usual comprehensive health coverage provides benefits. Attempts by travel accident insurers to provide more comprehensive coverage will cause the Department to raise concerns about mandated coverages, specified disease coverage and selling comprehensive coverage triggering open enrollment and community rating requirements (see above). Generally, this benefit is written as incidental to comprehensive health insurance coverage of the travelling insured at levels below Sections 52.5 and 52.6 of Regulation 62. The benefit sometimes provides necessary interim coverage when the insured's comprehensive health insurance excludes coverage when the insured is outside of the United States, United States possessions and the countries of Canada and Mexico. Benefits may be provided conditioned upon medically necessary treatment, and the fact that benefits are provided during a trip greater than 100 miles from a defined home area.
23. Trip cancellation/interruption benefits – Generally trip cancellation coverage provides benefits for losses incurred for trips cancelled up to the time and date of departure. Trip interruption coverage provides benefits for losses incurred for trips interrupted or delayed after the time and date of departure.

For example, an unforeseen injury or medical condition which affects the insured, a traveling companion of the insured or an immediate family member of the insured may cause the insured to delay, cancel or interrupt the trip. For trip cancellation due to these causes, the

insured might forfeit non-refundable trip payments or deposits which the travel insurance can reimburse sometimes with limits. For trip interruption, the travel insurance can reimburse the pro-rated portion of the cost of the part of the trip missed and associated expenses (early unplanned travel back home) sometimes with limits. To expand this narrow coverage, the Department will approve other triggering events besides an unforeseen injury or medical condition such as financial default of a tour operator, call of an insured, family member or travelling companion to military duty, terrorist act causing trip cancellation or delay and strikes, natural disasters or adverse weather causing trip cancellation or delay.

The Department reviews this benefit with a view toward encouraging insurers to expand the scope of coverage pursuant to Sections 3201(c)(3), 3217(b)(5) of the Insurance Law and Section 52.1(c) of Regulation 62.

24. Travel accident coverage – This component often provides the same kind of coverage as provided for flight insurance, except coverage is provided in broader settings (hotels, tour groups, etc.) than just being present on an aircraft or boarding or alighting from the aircraft. See above discussions concerning accidental death and dismemberment benefits.

Some insurers may classify emergency medical and dental benefits as “travel coverage”. See above discussions concerning emergency medical and dental benefits.

25. Repatriation benefits – This component pays a benefit should an insured die while on a trip to pay expenses for returning the human remains to the home destination. This benefit will be reviewed by the Department according to the parameters of Sections 3201(c)(3), 3217(b)(5) of the Insurance Law and Section 52.1(c) of Regulation 62.
26. Travel Accident Insurance – General Observations – The Insurance Department expects that the mandatory standard provisions of Section 3216(d)(1) and the optional standard provisions of Section 3216(d)(2) will be used regarding the accident and health components of travel accident insurance. The Department will consider the relevance of certain mandatory and optional standard provisions to a particular accident insurance filing if an accident insurer omits or modifies any of the mandatory and optional standard provisions in a particular accident insurance filing.

We refer the reader to the discussion above about including pre-existing condition time limits in accident insurance coverage (this includes travel accident coverage) only when appropriate. In addition, travel accident insurance of short duration is not the type of coverage where the Department would view a long pre-existing condition time period after coverage is effective as appropriate.

For example, attempts by travel accident insurers to include a two year pre-existing condition time limit exclusion after coverage is in force in a 90 day nonrenewable travel accident policy is considered violative of Section 3201(c)(3) of the Insurance Law.

The Department will entertain the addition of reasonable benefits to the accident and health components of a travel accident insurance policy so long as those benefits comply with Sections 3201(c)(3), 3217(b)(5) of the Insurance law and Section 52.1(c) of Regulation 62.

## X. Applications

1. If more than one application will be used, objective criteria is required to avoid unfair discrimination under Section 4224(b) of the Insurance Law. An example of unfair discrimination would be that, if two applications offer different levels of underwriting, two individuals would receive the same policy but undergo different levels of underwriting.

Insurers are reminded of their obligations under Section 4224(b)(1) as they pertain to the use of application forms with accident insurance policies. Objective and rational criteria must be used by the insurer to avoid unfair discrimination if the insurer is using multiple application forms with an accident insurance form so different applicants are subjected to different medical and financial underwriting in attempting to obtain coverage. When a submission is made of multiple application forms to be used with accident insurance where the Department could reasonably inquire about such obligations, the insurer should provide a detailed and prominent explanation in the submission letter about the use of multiple application forms with an accident insurance product.

2. Section 52.51(a) of Regulation 62 requires that an application cannot contain questions as to race of the applicant.
3. Section 52.51(b) of Regulation 62 requires that questions regarding past or present health of any person that refers to a specific disease or general health must be asked to the best of the applicant's knowledge and belief. Questions regarding factual information, such as doctor's visits or hospital confinements, do not require this qualification.
4. Section 52.51(c) of Regulation 62 requires that no application will contain a provision that changes the terms of the policy to which it is attached.
5. Section 52.51(d) of Regulation 62 requires that no application will contain a statement that the applicant has not withheld any information or concealed any facts.
6. Section 52.51(e) of Regulation 62 requires that no application will contain an agreement that an untrue or false answer material to the risk shall render the contract void.
7. Section 52.51(f) of Regulation 62 requires that no application will contain 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, except in conformity with Section 3204 of the Insurance Law.
8. Section 52.51(g) of Regulation 62 requires that applications for conversion policies may not contain questions as to the health of the person or persons entitled to conversion (where conversion from family coverage is offered).
9. Section 52.51(h) of Regulation 62 requires that applications for policies subject to Section 3216(d)(2)(D) or (E), "Insurance with Other Insurers", will contain a question or questions requiring information with respect to such other insurance.
10. Section 52.51(i) of Regulation 62 requires that if an insurer includes in a policy the optional standard provision under Section 3216(d)(2)(C), "Other Insurance in this Insurer", a statement describing the provision in the policy must be included in the application, or provided at the time of application by separate notice.
11. Section 52.51(j) of Regulation 62 requires that if a policy contains a provision with respect to "pre-existing conditions", a statement describing the policy provision must be included in the application OR provided at the time of application by delivery of the disclosure statement required by Section 52.54.
12. Previous HIV test results are NOT questioned, sought or used per Sections 3217(b) and 52.1 of Regulation 62. Information regarding the diagnosis or treatment of AIDS or ARC may be sought and used. Also, the insurer has the right to conduct its own medical tests as part of the underwriting process.

13. Individual accident insurers are reminded of their obligations under Section 2611 of the Insurance Law and Section 2782 of the Public Health Law regarding written informed consent, authorization and disclosure of confidential information when the insurer uses an HIV antibody test in underwriting. Circular Letters No. 3 (1989) and No. 5 (1997) are relevant.
14. If this filing contains a reference to a telephone or in-person interview, the interview is conducted in the following manner:

Any questions raised during the interview are limited to those questions appearing on the application (i.e., questions over the phone would be no different than those being asked in the application).

The applicant will have an opportunity to review and make corrections to those statements that were attributed to him/her in the interview.

Any information obtained in the interview that will be used in the underwriting process will be reduced to writing, signed by the applicant and attached to the policy in compliance with Section 3204 of the Insurance Law.
15. If an Investigative Consumer Report will be prepared or procured, the insurer complies with Section 380-c of the General Business Law by providing notice in the application or in a separate form.
16. If a Medical Information Exchange Center (such as a Medical Information Bureau) will be used, the insurer complies with Section 321 of the Insurance Law.
17. Section 420.18(b) of Regulation 169 requires that an authorization to disclose nonpublic personal health information specifies the length of time the authorization will remain valid (maximum 24 months).
18. Section 403(d) of the Insurance Law requires a fraud warning on the application form.
19. Section 3204 of the Insurance Law contains requirements that apply to application forms for individual accident insurance policies. An insurer may make insertions for administrative purposes only as long as the insertions are clearly not ascribed to the applicant. No other insertions or alterations of a written application will be made by anyone other than the applicant without his written consent.

## XI. Disclosure Requirements

1. Sections 52.54 and 52.61 of Regulation 62 set forth disclosure requirements which apply to individual accident insurance policies.

## XII. Marketing of Individual Accident Insurance Using Group Methods

The individual accident insurance checklist contains items pertaining to whether a filing is individual, "list bill" or franchise. The requirements for each category are listed in the checklist, and those requirements will not be repeated here. However, this individual accident insurance product outline will explain the necessity of including these items on the individual accident insurance checklist.

These items are a recognition of how individual accident insurance is generally sold in the New York State marketplace by insurers and their agents, brokers or other representatives. In the sale of individual

accident and health insurance, including accident insurance, it is generally recognized that individual sales on a “one to one” basis are the most time consuming and costly to administer. There is no ability to know beforehand the characteristics of the insureds who will purchase the individual product (as contrasted with true group coverage where, as an example, one knows the type of employer or association purchasing---e.g. coal miners vs. librarians). True individual sales only occur by individual solicitation where not many insureds are purchasing at a particular point of sale. The medical underwriting, if any, is generally detailed to obtain and process. Due to such factors, the minimum loss ratios in Regulation 62 for such coverage are generally lower than for group coverages or coverages where many sales are made at one time or where group characteristics are apparent. Similarly, the individual sale is usually an adhesion contract situation where the insurer retains most of the bargaining leverage at point of sale, and the insurer retains that superior bargaining position concerning various issues such as claim processing after individual coverage is in force. This situation aids in explaining why many of the Insurance Law provisions pertaining to individual accident and health coverages (such as standard provisions) are more detailed and protective of the individual insured. This same situation aids in explaining why many of the Regulation 62 provisions pertaining to individual accident and health coverage are also more detailed and protective of the individual insured.

Over the years, however, insurers have developed mechanisms in the individual accident and health insurance marketplace which are not solely individual sales. These mechanisms seek to market or offer the individual product using group or quasi-group type methods. Often, however, the insurer does not want to pass on all or some of the savings or advantages of marketing an individual product in a group or quasi-group type manner. Thus, insurance regulations become necessary to protect the consumer. In addition, even when the insurer seeks to pass on some of the savings or advantages, the group or quasi-group type arrangement is not present forever. Sometimes the individual product group-type sales arrangement does not meet statutory requirements in New York State. Statutory and regulatory requirements can determine whether the group or quasi-group type marketing methods for an individual product are appropriate, and how much of the advantage of those methods should be passed on to the insured and for how long. The integrity of the New York statute recognizing groups is important when considering the appropriateness of marketing or offering an individual product with group or quasi-group methods. The integrity of that statute is important so the public is not misled into believing an individual product (without all or some of the advantages of a group product) is a group product as recognized by law with the consequential advantages of a group product.

Based upon the foregoing, the individual accident insurance checklist has set forth the mechanisms through which individual accident insurance products can be marketed using group or quasi-group methods. The first method which is a step toward group or quasi-group methods is a payroll deduction arrangement. When this arrangement is used for premium payments with no discounts at all and no other type of group or quasi-group methods, the individual accident insurance product remains subject to regulation as an individual product. No group or quasi-group savings or advantages to any significant degree are claimed by the insurer, and the individual insured has the convenience of payroll deduction as long as the employer is willing to provide that convenience. Here the insurer will accept premium payments directly from an insured should the insured lose the convenience of payroll deduction or choose not to use payroll deduction to pay premiums.

The second method which is the next step toward group or quasi-group methods is “list bill.” One will not find this method as a statutory or regulatory exception to the statute which recognizes permissible groups in New York State. It has been a method recognized by the Insurance Department as an accommodation to insurers for over 30 years.

Essentially, insurers desiring to use this method must differentiate it from franchise insurance (see below) to retain the exclusive treatment as an individual product, including but not limited to the generally lower individual minimum loss ratio more favorable to the insurer. The Insurance Department views this method as the sale of very few individual policies at a common site or address (usually an employer or some association) with no exclusivity granted to the insurer, no sponsorship by the employer or

association, no mass marketing (i.e. - agent or representative engages in the “one on one” sale) and no contribution of premiums by the employer or association. The employer or association may remit or not remit premiums through the sending of a single bill to the common address of the employer or association where the few individual insureds work or have a membership. Generally, this situation goes further than the payroll deduction arrangement because there are a few sales at a small employer or association site, and the insurer provides actuarial justification to the Insurance Department that the “list bill” arrangement is worth some small discount.

The Department views the sale of very few individual policies as a “case by case” factually specific measurement. It should be clear in a “list bill” arrangement that the number of policies sold as a portion of the number of lives solicited is small. It should also be clear that the “list bill” arrangement is not being used as a substitute for franchise or group insurance especially to avoid the higher loss ratio requirements of franchise or group insurance. If the insurer or its agent were to obtain a disproportionate share of insureds as a portion of the number of lives solicited, there may be a likelihood that exclusivity, sponsorship, mass marketing and other indicia of franchise or group insurance are present. Generally, “list bill” arrangements are found at small employer or small association sites.

It is important to note that the “list bill” discount is dependent upon the factual circumstances noted here for its continued existence. Since the “list bill” arrangement as understood by the Insurance Department provides such marginal savings and advantages of a group or quasi-group nature and a rather small discount, the Insurance Department regulates the individual accident insurance product as still an individual product with the generally more favorable individual minimum loss ratio. However, due to the marginal savings and advantages, the Insurance Department requires that the small discount revert to the higher individual premium if the “list bill” situation goes out of existence, and the insured continues to pay his/her premium on a direct bill basis. Once the “list bill” situation goes out of existence and the marginal savings and advantages also do not exist, the insured is a usual individual insured who should pay the undiscounted individual rate like other individual insureds to avoid “unfair discrimination” under Section 4224 (b)(1) of the Insurance Law. Prominent disclosure in the form of the increased rate when the “list bill” situation ends must occur.

The third method which is the last method and the most expansive method of marketing or offering individual accident insurance products with group or quasi-group savings or advantages is franchise insurance. Sections 52.2 (k), 52.19 and 52.70 of Regulation 62 (11NYCRR52) should be consulted. Generally, individual accident insurance products are distributed on a mass merchandising basis, administered by group methods and provided with or without evidence of insurability. Sponsorship by an employer or association occurs and exclusivity in the marketing of the individual products is granted to a particular insurer. The individual contract mechanism is retained. So the legal relationship is directly between the insured and insurer with no group policy being issued to a group policyholder. However, the insurer is generally able to know beforehand the characteristics of the insureds (e.g. – bar association, medical society, etc.), and the insurer is generally able to obtain a significant number of insureds due to the sponsorship of the employer or association, exclusivity granted to the insurer in marketing the individual accident insurance product and more sizeable discounts for the insured. We are just short of marketing the product as group under New York law, but the employer or association does not enter the direct legal relationship of the insurance contract and is not the group policyholder.

In the franchise situation, the agent or insurer representative usually does less work because of the sponsorship and exclusivity. The insurer achieves economies of acquisition and administration as well as knowing there is some affinity or relationship among all the insureds purchasing the franchise individual product. Therefore, the Insurance Department requires that these factors accrue to the insured’s benefit in the regulation of the franchise individual product. A higher minimum loss ratio is required, and the insurer can allow the discount on the franchise product to remain if the franchise arrangement ends because of the sizeable savings and advantages occurring at point of sale which can be recognized over the lifetime of the franchise form. (These sizeable savings and advantages do not occur with the first two methods either resulting in no discount or the reversion to the higher individual rate. The Department will

allow an insurer to charge the higher individual rate upon termination of the franchise arrangement for any reason if the insurer provides actuarial justification as to why the franchise savings and advantages do not warrant continuation of the discount upon termination of the franchise arrangement. In that instance, prominent disclosure of the higher rate in the form is necessary as with the “list bill” arrangement.)

### XIII Conditional Receipts/Interim Insurance Agreements

Section 52.53 of Regulation 62 requires that, if premium is paid prior to policy delivery and the insurer requires a determination of insurability as a condition precedent to the issuance of a policy, an insurer must issue either a conditional receipt or interim insurance agreement. In general, Section 52.53 sets forth two permissible methods for money to be accepted with an application – conditional receipt or interim insurance agreement. Section 52.53(c) defines a “determination of insurability” as a determination by the insurer 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 insurer’s standard premium rate.

1. A conditional receipt sets an effective date for the policy if the applicant successfully completes the underwriting process. The conditional receipt shall contain an agreement to provide coverage subject to any reasonable limit regarding the amount of insurance specified in the receipt, contingent upon insurability, and provides that such insurability be determined as of a date no later than:

The date of completion of all parts of the application, including completion of the first medical examination if one is required by the company’s underwriting rules,  
AND

The required premium has been paid.

Completion of a second medical examination may be required as a condition precedent to coverage if initially required by the company’s underwriting rules because of the amount of insurance applied for or the age of the proposed insured.

If the proposed insured is insurable as of the above date, coverage under the issued policy begins not later than such date, except as provided in paragraph 4 below. Section 52.53(a) of Regulation 62.

2. Although the proposed insured dies, undergoes a change in health or otherwise becomes uninsurable according to the insurer’s underwriting standards for the insurance plan for which application was made after the date provided in paragraph 1 above but before the application is approved or rejected and before the expiration of any time limit specified in the receipt, an insurer may determine that the proposed insured is not insurable only as of the date stated in paragraph 1. Information relating to an event or physical condition that is the subject of a question in any part of the application cannot be considered for underwriting purposes if the event or accident occurred or sickness first manifested itself after completion of that part of the application. Adverse changes in insurer underwriting rules after the date stated in paragraph 1 cannot be taken into account when such adverse changes in underwriting rules take effect after the date stated in paragraph 1 but before the application is approved or rejected and before the expiration of any time limit specified in the receipt. (In summary, policy underwriting can only be based on the insured’s health status as of the date provided for in paragraph 1.) Section 52.53(e) of Regulation 62.

Suppose an accident insurance applicant pays premium with his/her application, and the insurer issues a conditional receipt to the applicant on December 1, 2002. The applicant completes all parts of the application truthfully on December 1, 2002, and the applicant awaits the insurer's underwriting decision. Then assume on December 8, 2002 (which is before the expiration of a 60 day time limit in the receipt), the applicant suffers an accident which would be covered under the accident insurance policy applied for (but not yet issued because the insurer is in the process of underwriting). The applicant begins to incur covered loss on December 15, 2002. Then assume the applicant dies on January 27, 2003. The insurer would be using its underwriting rules in effect on December 1, 2002,

and the insurer would be assessing the insured's health as of December 1, 2002 based upon a truthful application submitted by the applicant on December 1, 2002. The insurer would issue an accident insurance policy dated effective December 1, 2002. Since the accident insurance policy issued covered the December 8, 2002 accident, the insurer would be obligated to pay for the covered loss according to policy terms from December 15, 2002 until January 27, 2003. This might all occur retrospectively if the insurer used the full 60 day period mentioned in the conditional receipt and did not issue the accident insurance policy with a December 1, 2002 effective date until January 29, 2003.

3. An interim insurance agreement provides some type of immediate limited insurance coverage as of the application date. The agreement provides coverage in accordance with the policy and plan of insurance described in the application subject to any reasonable limit regarding the amount or duration of insurance specified in the agreement. Coverage is provided as of the application date and must provide at least 60 days coverage unless:

The policy applied for is issued prior to the end of the 60 days, OR

The applicant receives actual notice that coverage under the agreement is cancelled because the application has been declined. If notice is given by mail, it may be deemed received on the fifth day after mailing such notice to the applicant. Section 52.53(b) of Regulation 62.

4. An insurer may honor a written request from the applicant that coverage begins as of a specified date later than the date provided for in the conditional receipt or interim insurance agreement. In other than replacement situations, the applicant's written request for a later effective date must contain a statement signed by the applicant that he/she understands that he/she may be waiving certain rights and guarantees under the conditional receipt or interim insurance agreement. Section 52.53(f) of Regulation 62.
5. If coverage is provided under a conditional receipt or interim insurance agreement for two or more proposed insureds, the coverage must be determined separately for each proposed insured, except, however, all proposed insureds may be rejected in the event of fraud or material misrepresentations. Section 52.53(d) of Regulation 62.
6. If a policy is not issued within the time specified in the conditional receipt or interim insurance agreement, the application will be deemed rejected and all premiums will be refunded. Section 52.53(i) of Regulation 62.
7. In mail order cases only, an insurer may postpone the effective date of coverage to the date of issuance of the policy. Section 52.53(g) of Regulation 62.
8. In franchise cases, the coverage under the conditional receipt or interim insurance agreement may be made contingent upon meeting specified participation requirements. Section 52.53(h) of Regulation 62.

The Department will entertain reasonable alternatives to Section 52.53 requirements, but any alternative must be as favorable for an insured as Section 52.53 requirements. The insurer cannot take the most favorable aspects of a conditional receipt and interim insurance agreement for an insurer and submit a hybrid form that is not as favorable for an insured as under Section 52.53.

#### XIV. Rating Procedures and Requirements

1. Section 52.40 (a) of Regulation 62 sets forth general procedures and requirements which apply to the rating of accident insurance forms.

2. Section 52.40 (b) of Regulation 62 sets forth prohibited rating practices which may be applicable to accident insurance forms.
3. Section 52.40 (c) of Regulation 62 sets forth requirements applicable to individual accident insurance forms.
4. Section 52.40 (d) of Regulation 62 sets forth requirements applicable to individual accident insurance forms.
5. Section 52.41 of Regulation 62 sets forth gross premium differentials based on sex which apply to individual accident insurance forms.
6. Section 52.43(a) of Regulation 62 sets forth standards for maintaining experience data which apply to individual accident insurance forms.
7. Section 52.44 (b) of Regulation 62 sets forth monitoring standards which apply to individual accident insurance forms.
8. Section 52.45(a), (b), (c), (d) and (e) of Regulation 62 sets forth minimum loss ratio standards which apply to individual accident insurance forms.