

**PRODUCT OUTLINE**  
**INDIVIDUAL DISABILITY INCOME**  
As of 8/1/03

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## 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, 52.8, 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 52.60 (disclosure requirements), Regulation 169 (11 NYCRR 420) privacy of consumer financial and health information including Section 420.18.

Key Circular Letters – Circular Letter No. 21 (1982), Circular Letter No. 3 (1989), Circular Letter No. 5 (1997)

## 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 52.8 of Regulation 62.
5. Include "free look" provision within parameters of Section 3216 (c)(10).
6. Form identification number in lower left-hand corner of form – Section 52.31 (d).
7. Renewability provisions of form to be placed on the front page of the policy form – Section 52.17 (a)(1)(2).
8. 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 disability income 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, or as an alternative, until receipt of retirement benefits under the Social Security Act of the United States. 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, or as an alternative, until receipt of retirement benefits under the Social Security Act of the United States. 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.

A disability income 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 a disability income form indicates if a person retires or no longer engages in an occupation then coverage ceases immediately upon retirement or cessation of employment (other than by reason of disability). If the insurer has accepted premium for a time period during which retirement or employment cessation occurs, coverage must be provided to the end of the time period. The insurer can base disability benefits on a revised definition (e.g. – insured is unable to perform the usual activities of a person of like age and sex) for any time period when a person has retired or ceases to be employed for a reason other than disability. The insurer needs to take affirmative action in ascertaining whether a person has ceased employment for reasons other than disability or retired to determine whether premium should be accepted.

9. 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. Elimination period choices, maximum benefit period choices, 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 space – 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 disability income 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 disability income 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).

Must include a preexisting condition time period complying with Section 3216(d)(1)(B)(ii).

Section 3216(d)(1)(B)(ii) sets a two-year time period from the coverage issuance date for a disability income insurer to exclude coverage for preexisting conditions. For disability income 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 disability income coverage unrelated to disability definitions (e.g. – incidental benefits such as hospital indemnity benefits or non-disabling sickness or 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).

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 disability income 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).
13. When applicable, must include “Conversion Privilege” provision – Section 3216 (d)(1)(M).

#### 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).
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 chooses to place 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 pregnancy, must comply with Section 52.16 (c)(3) of Regulation 62.
4. 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).

5. 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.
6. 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.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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.
12. 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.

13. 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).
14. Individual accident and health coverages, including disability income 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. If policy contains accident benefits, 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. Disability income 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. Disability 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. 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.
12. No disability income 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.
13. No disability income form shall reduce benefits solely on the basis of the sex or marital status of the insured – Section 52.17 (c)(3) of Regulation 62.
14. 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.
15. 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. Form definition of “occupation” must be meaningful as used in a disability income policy, fair to the consumer and fully disclosed in the policy language – originates from Sections 3201 (c)(3), 3217 (b) of the Insurance Law and Sections 52.1 (c), 52.1 (d) and 52.8 of Regulation 62.
2. Form definitions of “disability”, “total disability”, “residual disability”, “concurrent disability”, “recurrent disability”, “partial disability” and similar terms must be meaningful as used in a disability income policy, fair to the consumer and fully disclosed in the policy language – originates from Sections 3201 (c)(3), 3217 (b) of the Insurance Law and Sections 52.1 (c), 52.1 (d) and 52.8 of Regulation 62.

Disability income forms often contain provisions regarding “recurrent disabilities”, “concurrent disabilities” and terms of similar import. Essentially, the insurer explains in such provisions how the coverage will pay one income benefit (usually monthly) for a defined disability no matter how many causes (e.g. – how many sicknesses or injuries cause the disability). Such provisions also explain when the insurer deems subsequent disabilities to be related to a prior disability (i.e. – in sum, how much recovery time must elapse before a later disability is eligible for a new benefit period and a new elimination period and is not deemed to be still satisfying an elimination period of a prior disability period or still running out the benefit period of a prior period of disability).

The Department will review such provisions according to the standards noted in Sections 3201 (c)(3), 3217 (b) of the Insurance Law and Sections 52.1 (c) , 52.1 (d) and 52.8 of Regulation 62.

3. Form definition of “complications of pregnancy” and pregnancy must comply with Section 52.2 (e) of Regulation 62, and all pertinent federal statutes, regulations and requirements.
4. Form definitions of consumer price indexes and consumer price index factors commonly used in individual disability income forms must be meaningful as used in a disability income form, fair to the consumer and fully disclosed in the form language. Disability income insurers which reserve the right to change the consumer price index used to calculate policy adjustments in a disability income form should indicate in the form language that any new index chosen by the insurer or change to a present index made by an insurer will be subject to the prior approval of the Superintendent of Insurance (or, as a more general alternative, subject to the approval of the insurance regulatory authority of the state where the form was delivered or issued for delivery when required). An insurer which makes changes in an index or chooses a new index is essentially reserving the right to materially affect future form benefits for which an insured pays premiums based upon an index. This right of an insurer to change an index or choose a new index can make the benefit illusory if the insurer’s action reduces or eliminates form benefits in the future based upon the index. This would be contrary to Section 3201 (c)(3) of the Insurance Law. In addition, future changes to a present index or choosing a new index in the future will vary the language of an approved form, and this requires approval of the wording describing the new index or index changes under Section 3201 (b)(1) of the Insurance Law. Changes to form language must appear in the contract of insurance under Section 3204 (a)(1) of the Insurance Law. – originates from Sections 3201 (b)(1), 3201 (c)(3), 3204 (a)(1), 3217 (b) of the Insurance Law and Sections 52.1 (c), 52.1 (d) and 52.8 of Regulation 62.
5. Form definitions of “elimination period”, “waiting period”, or similar provisions which set a time period before disability benefits will be paid must be meaningful as used in a disability income 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) and 52.8 of Regulation 62.

In general, the Department views an elimination period or waiting period of no longer than 180 days as reasonable. The elimination period or waiting period length is acceptable as a choice for an insured among various options such as 0-day, 60 days, etc. The elimination period or waiting period can serve as a mechanism for insured choices as to the amount of time the insured wants to self-insure income losses from disability. The elimination period or waiting period can serve as a mechanism for premium affordability for an insured since the longer the insured self-insures the income loss the less premium the disability income insurer should charge for shortened insurer liability.

However, extremely long elimination periods or waiting periods may work a hardship on a disabled insured since he/she would be receiving no benefits during a period of income loss associated with a disability. Such extremely long elimination periods or waiting periods may enable an insurer to provide no coverage because the disabled insured might recover before expiration of the elimination period or waiting period. The entire need for disability income coverage with a long elimination period or waiting period would then be questionable.

Insurers offering disability income coverage with elimination or waiting periods of greater than 180 days should explain in their submission letter how such a mechanism offers the insured meaningful coverage.

6. Form definition of “hospital” as used in an individual disability income form must comply with Section 52.2 (m) of Regulation 62.

7. Form definitions of “injuries”, “sickness”, “preexisting condition”, “first manifest”, “first diagnosed or treated” or similar terminology must be meaningful as used in a disability income 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 52.8 of Regulation 62.
8. Form definitions of “Loss of Earnings”, “Monthly Earnings”, “Prior Earnings” and similar terms used to calculate income losses due to disabilities must be meaningful as used in a disability income form, fair to the consumer and fully disclosed in the form language.

For examples, “Prior Earnings” is sometimes defined as the greater of an insured’s monthly earnings: 1. for the twelve months just prior to the disability for which claim is made or 2. for the calendar year with the higher earnings of the last two calendar years prior to the disability for which claim is made. “Monthly Earnings” is sometimes defined as salary, wages, commissions, bonuses, fees and income earned for services performed. If the insured owns any portion of a business or profession, “monthly earnings” is defined as: 1. the insured’s share of income earned by that business or profession, 2. less your share of business expenses that are deductible for federal income tax purposes, 3. plus your salary and any contribution to a pension or profit sharing plan made on your behalf. “Loss of Earnings” for any month is sometimes defined as “Prior Earnings” less “Monthly Earnings” in the month for which a benefit is claimed so long as the “Loss of Earnings” is due to a sickness or injury that caused the disability and the “Loss of Earnings” is at least 20% of “Prior Earnings”.

The Department mentions the foregoing as illustrations of reasonable definitions, but we would consider other definitions. For guidance, prior earnings must involve a time period prior to the disability for which claim is made, but the time period should be immediately prior to the disability and for a sufficient length to reflect the insured’s prior earnings in a recent time frame to achieve a meaningful disability benefit. Also, the benefit trigger for “Loss of Earnings” as a percentage of “Prior Earnings” should be no greater than 25%. The Department can accept some minimal uninsured loss of income requirement before disability benefits are triggered because a relatively small income loss may be subject to insured manipulation, and such an uninsured relatively small income loss can aid in premium stability. However, the above noted percentage should serve as an illustration of what the Department considers reasonable.

Insurers desiring to use the “Relation of Earnings To Insurance” provisions in Section 3216(d)(2)(F) of the Insurance Law (i.e.- insurers touching upon the subject matter governed by Section 3216(d)(2)(F)) must use that statutory section verbatim or different wording not less favorable in any respect to the insured – see 3216(d)(2)). We mention this issue because Section 3216(d)(2)(F) prescribes a statutory method for reduction of disability income benefits from all sources with a premium refund when the insured’s earnings at defined statutory times do not warrant the amount of disability benefits from all sources at defined statutory times. Insurers using Section 3216(d)(2)(F) should comply with it, and forms definitions must be consistent with or distinct from Section 3216(d)(2)(F) depending upon how the insurer integrates the subject matter of Section 3216(d)(2)(F) into the benefit structure of the disability income form.

9. Form definitions of “maximum benefit periods”, “benefit periods”, or similar provisions which set a maximum time period for payment of disability benefits must be meaningful as used in a disability income form, fair to the consumer and fully disclosed in the form language. Reductions in benefit periods due to attainment of age limits must be prominently disclosed by placement on the form face page or specification page – originates from Sections 3201 (c)(3), 3217 (b) of the Insurance Law and Sections 52.1 (c), 52.1 (d), 52.17 (a)(3) and 52.8 of Regulation 62.

In general, the Department views as reasonable a maximum benefit period of at least one year. The Department notes, however, that there is interaction between a maximum benefit period and an elimination period or waiting period. Insurer options which couple short benefit periods with long elimination periods or waiting periods reducing insurer liability for disability income benefits to a less than meaningful coverage amount would result in comments from the Department on such a submission.

For guidance, the Department generally accepts as reasonable (depending upon the nature of the disability income coverage and relationships to other benefit mechanisms such as elimination or waiting periods) maximum benefit period choices of 1, 2 and 5 years and “to age 65”. For certain types of disability income coverage (e.g.- professional occupational classifications or risks difficult to place) the Department has approved lifetime maximum benefit periods, and we can accept lifetime maximum benefit periods as reasonable.

However, the Department notes that often extremely long maximum benefit periods are coupled with dual definitions of total disability. For example, an insured with a “to age 65” maximum benefit period might also have a time limited definition of total disability. The insured for a time may be deemed totally disabled if he/she is unable to perform the material and substantial duties of his/her own occupation, but after ten years may be deemed totally disabled if he/she is unable to perform the material and substantial duties of any occupation. The transitional definition of total disability may result in an insured with a “to age 65” maximum benefit period having benefits terminated long before age 65 because he/she could perform some occupation even if it was not his/her own occupation (e.g.-disabled surgeon after ten years could become a family practitioner or medical school professor). The Department generally views these types of benefit structures as ones which require clear explanation in the policy form language for disclosure to the insured. These types of mechanisms need to be reasonably applied by the insurer at the time of claim depending upon the specific facts and medical condition of any particular insured. In addition, these types of mechanisms can serve as an incentive for an insured (who is able) to return to some type of appropriate work thereby lessening the need for coverage on a given claim. This aids in maintaining premium stability for the coverage.

10. Form definition of “mental disorders” must be meaningful as used in a disability income form, fair to the consumer, and fully disclosed in the form language – originates from Sections 3201 (c)(3), Sections 3217 (b), 4224 (b)(2) of the Insurance Law and Sections 52.1 (c), 52.1 (d) and 52.8 of Regulation 62.
11. Form definition of “physician” or any substitute terms cannot unduly limit access of the insured to disability income benefits under the form – originates from Sections 3201 (c)(3), 3217 (b) of the Insurance Law and Sections 52.1 (c), 52.1 (d) and 52.8 of Regulation 62.
12. Form provisions dealing with waiver of premium during period of disability resulting from injuries or sickness or assignments must be meaningful as used in a disability income 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), 52.8 and 52.16 (b) of Regulation 62.
13. Form provisions which are drafted to provide total disability benefits using defined form terms must be constructed so as to provide a meaningful benefit amount, for a meaningful time period after any reasonable time delay before benefits are paid. For example, total disability monthly benefit amounts bearing a reasonable relationship to the lost income of the insured due to an inability to perform the substantial and material duties of one’s own

occupation or another occupation after a 30 day elimination period would be meaningful and fair to the consumer if fully disclosed in the form language – originates from Section 3201 (c)(3) of the Insurance Law and Sections 52.1 (c), 52.1 (d) and 52.8 of Regulation 62.

14. Form provisions which are drafted to provide less than the entire benefit amount for total disability for periods of time when the insured might be able to work part-time or work full-time but not perform all occupational duties (e.g. – residual disability benefits, partial disability benefits, or similar benefits) must be constructed so as to provide a meaningful benefit amount, for a meaningful time period after any reasonable time delay before less than full form benefits are paid. For example, a policy form formula where current earnings for abbreviated work due to residual disability are subtracted from prior earnings before disability began and that loss of earnings is calculated as a percentage of prior earnings and the percentage is applied to the total disability benefit to arrive at the residual disability benefit payable is generally acceptable. The formula would be acceptable so long as the definitions for current earnings, loss of earnings and prior earnings meet the standards stated in IX.8. above - originates from Section 3201 (c)(3), 3217 (b) of the Insurance Law and Sections 52.1 (c), 52.1 (d) and 52.8 of Regulation 62.
15. Form provisions drafted to provide voluntary rehabilitation benefits when the insured and insurer (and some other acceptable parties such as the insured’s medical provider or insured’s immediate family) agree in writing as to the nature of the benefits and amount payable are approvable. In accordance with Section 3201 (c)(3) of the Insurance Law, such provisions cannot be drafted to compel an insured to participate in a program for which the insured does not want to participate. The provision as drafted should be constructed to aid the insured in returning to work.
16. 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 a disability income 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 a disability income 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.

17. Form provisions drafted to expand or limit access to disability benefits under the form based upon occupational performance are acceptable as a general matter. These provisions must allow for a reasonable access to disability benefits under the form no matter how occupational performance is set forth in the coverage. For example, a form which would pay benefits when an insured is disabled from performing his/her “own occupation” when disability began, but then limits benefits after a time period to only when an insured is disabled from performing his/her “own occupation” or “any other occupation for which the insured is fitted by reason of education, training or experience” would be approvable – originates from Sections 3201 (c)(3), 3217 (b) of the Insurance Law and Sections 52.1 (c), 52.1 (d) and 52.8 of Regulation 62.

18. Form provisions providing update increases or future guaranteed option increase dates or events where disability 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 disability 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 52.8 of Regulation 62.

19. Form provisions which coordinate or integrate disability benefits with benefits payable from other individual or group health or disability policies are not approvable in New York State for use in individual disability income forms – Section 52.23 (e)(3)(i) of Regulation 62.
20. Form provisions which coordinate or integrate the benefits of social insurance programs with benefits under individual disability income policies are not approvable in New York State unless done in a manner consistent with Section 3216 (d)(2)(F) of the Insurance Law.
21. In order to provide insurers with flexibility in the design of individual disability income forms where the insurer desires to take account of coverage an insured receives from other social insurance programs, the Department issued Circular Letter No. 21 (1982) on June 29, 1982. This summary of Circular Letter No. 21 (1982) should not be used as an alternative to a review of the entire circular letter and compliance with its entire contents.

Acceptable social insurance programs for consideration as subjects of non-duplication with disability income form benefits are workers' compensation, occupational disease laws and social security. The type of coverage contemplated is where the benefits of the disability income coverage substitute for the benefits of the social insurance program and are not a supplement to the social insurance program. Accordingly, misleading titles such as "social insurance supplement" coverage should not be used and titles such as "social insurance substitute" coverage would be approvable.

Often the social insurance substitute coverage is not unconditionally guaranteed renewable or noncancellable within the meaning of Sections 52.17 (a)(5)(6)(7) of Regulation 62, while the policy to which the social insurance substitute rider is attached or within which the benefit is contained, is guaranteed renewable or noncancellable within the meaning of Sections 52.17 (a)(5)(6)(7). In the event of differing renewal provisions, the social insurance substitute coverage must have its own renewal provision and appropriate caption. If the social insurance substitute coverage is contained within the policy with differing renewal conditions, both sets of renewal conditions (or appropriate captions with cross references) must be clearly set forth on the face page. Any captions must clearly highlight renewal condition differences. If the social insurance substitute coverage is contained in a rider, some reference to the different rider renewal provision should appear on the schedule page. When the renewal provisions of the social insurance substitute coverage do not meet the requirements of Sections 52.17 (a)(5)(6)(7) of Regulation 62, the terms authorized by Sections 52.17 (a)(5)(6)(7) cannot be used with the social insurance substitute coverage. The Department will allow premium for the social insurance substitute coverage to be increased in

the case of a noncancellable policy if Congress eliminates the Social Security disability benefit but not in excess of the premium rate at issue for base coverage of the same amount.

The Department will approve social insurance substitute coverage provisions which require insureds to apply for coverage under an acceptable social insurance program when it appears entitlement to some benefits exist. Such provisions may also require an individual whose claim for Social Security benefits has been denied to periodically re-apply for benefits according to reasonable re-application standards.

The Department will approve a provision that requires an insured to request reconsideration of a denied application for coverage under a social insurance program. The insurer can also require an appeal of a denied social insurance program application if circumstances for an appeal appear reasonable. The Department will not approve a provision which requires an insured denied social insurance program coverage to incur expenses in pursuing an appeal required by the insurer.

The Department notes that often insurers submit social insurance substitute provisions which impose penalties on an insured for failure to apply for coverage under social insurance programs. The Department will not approve a provision which conditions the payment of all or part of any guaranteed base benefits in the policy upon the insured applying for coverage under a social insurance program since the base policy benefits are not related to the receipt of benefits under the social insurance program. The Department will not approve a provision which penalizes an insured by forfeiture of social insurance substitute disability benefits (in whole or part) unless the insured applies for social insurance program coverage within a specified time after the date on which the insured is first entitled to apply. (This would contravene Section 3201 (c)(3) of the Insurance Law and Section 52.16 (c)(8) of Regulation 62.)

The Department will approve a provision which suspends social insurance substitute disability benefits to encourage insureds to apply for social insurance program benefits. An example of language of this type which the Department would approve is as follows:

- 1) A policy or rider furnishing social insurance substitute disability benefits may provide that, upon determination that the circumstances of a claim make it reasonably probable that the insured is entitled to apply for coverage under a social insurance program, the insurer may require the insured to apply under such program within ten days after receipt of written notice from the insurer of his obligation to do so. Such a policy or rider may further provide that, unless within 30 days thereafter, the insurer is furnished with satisfactory evidence that such application has been made within ten days, it will discontinue the payment of its substitute disability benefits under the policy from the end of the ten day period after receipt of such notice and will not resume the payment of such benefits until a date on which such application has actually been made.
  - 2) With respect to Social Security Disability Benefits, if the elimination period for the social insurance substitute disability benefits is between 6 months and one year the insurer may require the insured to apply for Social Security Disability benefits not later than five months after the onset of total disability, and may further provide that, in the event such application for benefits is deferred later than such specified time, the length of elimination period applicable to social insurance substitute disability benefits may be increased by the length of such deferment of application.
22. The Department believes that some insurers in other jurisdictions provide disability income coverage based upon the origin of the disability (occupational vs. non-occupational) as related to work endeavors or unrelated to work endeavors. Insurers have designed disability income coverages where no benefits whatsoever are paid when a disability results from an

origin “on the job” (occupational) presumably on the basis other governmental related benefits are paid for the disability with an “on-the-job” origin. The Department has not found this approach acceptable since it encourages the fragmentary sale of two disability income policies (for work related and unrelated to work disabilities). The approach also contravenes Section 52.16 (c)(8) of Regulation 62.

Where it is clear that an individual disability income policy design is not intended to cover the subject matter described in Circular Letter No. 21 (1982), the Department will approve an individual disability income policy which reduces the benefit payable by, for example, the benefits actually paid by workers’ compensation. This approach encourages comprehensive disability income coverage, and only allows a policy benefit reduction by actual payment of workers’ compensation benefits. This approach does not require restrictive policy language as to coverage of only disabilities unrelated to work. This approach does not leave an insured with no benefits when the disability income insurer denies benefits for a work related disability, but the workers’ compensation carrier might refuse payment for a technical reason or the insured does not apply for workers’ compensation.- Sections 52.1(c), 52.16(c)(8), 3217(b)

23. Insurers in the individual disability income market are reminded of their obligations under Section 3228 of the Insurance Law.

#### 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 disability income 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 a disability income 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 disability income 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 a disability income 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.
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 disability income 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 disability income 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 52.60 of Regulation 62 set forth disclosure requirements which apply to individual disability income policies.

XII. Marketing of Individual Disability Income Insurance Using Group Methods

The individual disability income 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 disability income insurance product outline will explain the necessity of including these items on the individual disability income checklist.

These items are a recognition of how individual disability income 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 disability income 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 disability income insurance checklist has set forth the mechanisms through which individual disability income 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 disability income 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 disability income 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 disability income 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 disability income 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 disability income 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 a disability income 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 is diagnosed with a severe condition causing disability which would be covered under the disability income policy applied for (but not yet issued because the insurer is in the process of underwriting). The applicant begins to incur covered loss of income 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 a disability income policy dated effective December 1, 2002. If the disability income policy issued had a 0-day waiting period for covered loss of income, the insurer would be obligated to pay for covered loss of income 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 disability income 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 disability income forms.
2. Section 52.40 (b) of Regulation 62 sets forth prohibited rating practices which may be applicable to disability income forms.
3. Section 52.40 (c) of Regulation 62 sets forth requirements applicable to individual disability income forms.
4. Section 52.40 (d) of Regulation 62 sets forth requirements applicable to individual disability income forms.
5. Section 52.41 of Regulation 62 sets forth gross premium differentials based on sex which apply to individual disability income forms.
6. Section 52.43(a) of Regulation 62 sets forth standards for maintaining experience data which apply to individual disability income forms.
7. Section 52.44 (b) of Regulation 62 sets forth monitoring standards which apply to individual disability income forms.
8. Section 52.45(a), (c), (d) and (e) of Regulation 62 sets forth minimum loss ratio standards which apply to individual disability income forms.

