

PRODUCT OUTLINE
GROUP DISABILITY INCOME
As of 7/7/08

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I. Key References

Key Insurance Law Sections – 3102, 3105, 3201 (Form Approval issues), 3221, especially 3221(a) (standard provisions) and 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, 52.18, 52.31, 52.33, 52.40, 52.41, 52.43, 52.45 (minimum loss ratio standards), 52.51 (applications) and 52.53 (conditional receipts/interim insurance agreements), Regulation 145 (11 NYCRR 360) and Regulation 169 (11 NYCRR 420) privacy of consumer financial and health information including Section 420.18.

Key Circular Letters – Circular Letter No. 3 (1989), Circular Letter No. 5 (1997), Circular Letter No. 14 (2007), Supplement No. 1 to Circular Letter No. 14 (2007).

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. Form identification number in lower left-hand corner of form – Section 52.31(d).
6. 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. 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).
3. 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. Standard Contract Provisions

1. May include a grace period provision for premium payment in accordance with Section 3221(a)(4).
2. Must include a notice of claim provision in accordance with Section 3221(a)(8).
3. Must include a claim forms provision in accordance with Section 3221(a)(10).
4. Must include a proofs of loss provision in accordance with Section 3221(a)(9).

5. Must include a payment of claims provision in accordance with Section 3221(a)(12).
6. Must include a physical examinations and autopsy provision in accordance with Section 3221(a)(11).
7. Must include a legal actions provision in accordance with Section 3221(a)(14).
8. When applicable, must include a change of beneficiary provision in accordance with Section 4235(e).
9. Must include a provision concerning statements made by an insured in accordance with Section 3221(a)(1).
10. Must contain a provision regarding authority to make changes to the policy in accordance with Section 3221(a)(2).
11. Must issue a certificate in accordance with Section 3221(a)(6).
12. Must include a provision detailing the conditions under which the insurer may decline to renew the policy in accordance with Section 3221(a)(5).
13. Must include a provision that states all new employees or new members in the classes eligible for insurance will be added to the class for which they are eligible in accordance with Section 3221(a)(3).
14. Must include a provision containing the ages to which the insurance provided shall be limited and the ages for which additional restrictions are placed on benefits and the additional restrictions placed on the benefits at such ages in accordance with Section 3221(a)(7).
15. Must include a provision stating that indemnity for loss of life of the insured is payable in accordance with Section 4235(e) and that all other indemnities of the policy are payable to the insured, except as may be otherwise provided in accordance with such subsection; and that if a beneficiary is designated, the consent of the beneficiary shall not be requisite to change of beneficiary, or to any other changes in the policy or certificate, except as may be specifically provided by the policy in accordance with Section 3221(a)(13).

VI. Optional Standard Provisions

1. If insurer chooses to offset benefits then must comply with Section 52.18(d) of Regulation 62:

Offsets in group contracts may apply to service type plans, prepaid group practice plans, group and blanket insurance, self-insured or noninsured plans, franchise plans, group salary continuance programs, State or Federal programs except Medicaid and mandatory no-fault automobile insurance benefits – Section 52.18(d)(1).

Life, annuity or pension benefits under a plan of the same or a related employer may be offset against disability income benefits, subject to the following: early retirement benefits may be offset only if such early retirement is elected by the employee or does not reduce the amount of his accrued annuity or pension benefits then funded - Section 52.18(d)(2)(i).

2. If insurer chooses to place an illegal occupation provision in the coverage, must comply with Section 3216(d)(2)(J). See also Section 3221(c).

3. If insurer chooses to place an intoxicants and narcotics provision in the coverage, must comply with Section 3216(d)(2)(K). See also Section 3221(c).

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 52.18(a)(5) of Regulation 62 and Section 3234, as added by L.1993, c. 650 of the Insurance Law. Credit for prior group disability income coverage shall be given to the extent that the previous coverage or level of benefits was substantially similar to the new coverage or level of benefits. See Section 3234(a)(1). In accordance with Circular Letter No. 14 (2007), the language of the forms should clearly indicate that any pre-existing condition provision is a waiting period, and not a complete bar for coverage of those disabilities that arise within the first 12 months of coverage.
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. See also Section 3221(c).
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.
5. 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 Section 3221(n).
6. 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.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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.

12. 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.
13. 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.

14. 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).

*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 Group Insurance

1. If policy contains accident benefits, accident benefits cannot be predicated upon loss occurring through violent and external means – Section 52.18(b)(1) of Regulation 62.
2. 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 52.18(b)(3) of Regulation 62.
3. Disability benefits conditioned upon hospital confinement shall be considered as hospital, medical or surgical expense benefits for purposes of Section 3221(e) of the Insurance Law and any relevant regulations – Section 52.18(b)(7) of Regulation 62.
4. Where disability income benefits are integrated with social security benefits, the policy shall provide that the amount of any disability benefits actually being paid to a disabled person shall not subsequently be reduced by changes in the level of social security benefits resulting from cost of living adjustment or changes in the Social Security Law which became effective after the first day for which disability benefits became payable - Section 52.18(b)(13)
5. Insurers making unilateral modifications to existing coverage must provide 30 days written notice to policyholders – Section 52.18(a)(8).
6. Conditions of eligibility pertaining to employment under Section 4235(c) include geographic situs of employment, earnings, method of compensation, hours and occupational duties – Section 52.18(f).
7. A family policy shall provide that adopted children and stepchildren dependent upon the insured be eligible for coverage on the same basis as natural children - Section 52.18(e)(2).

A family policy covering a proposed adoptive parent on whom the child is dependent shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption - Section 52.18(e)(3).

8. No group policy replacing a plan of similar benefits of another insurer or self-insurer shall be written unless all persons of the same class insured under the prior plan are eligible without evidence of individual insurability or restrictions as to preexisting conditions, except those contained in the policy from which transfer is made to the extent of the lesser of the prior coverage or the coverage provided under the replacing plan – Section 52.70(e)(1).

IX. Other Provisions

1. Policies must be issued to one of the permissible groups set forth in Section 4235(c)(1).
2. If an employer is going to pay for 100% of the premium amount the all eligible employees must be covered under the policy – Section 4235(c)(1)(A).
3. 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 in accordance with the requirements of Section 52.53 of Regulation 62.
4. 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.
5. 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.

6. Form definition of “complications of pregnancy” must comply with Section 52.2(e) of Regulation 62, and all pertinent federal statutes, regulations and requirements.
7. Form definitions of consumer price indexes and consumer price index factors 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.

8. 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 also serves 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.

Accordingly, filings that provide for elimination periods longer than 180 days typically will be disapproved pursuant to Insurance Law Section 3201(c)(3). Nevertheless, the Department will consider approval of an elimination period greater than 180 days where the insurer adequately explains why it is necessary

In addition, in accordance with Supplement Number 1 to Circular Letter No. 14 (2007), the Department expects elimination periods and pre-existing condition waiting periods in group and blanket disability policies to run concurrently rather than consecutively. The issue arises in the very narrow set of circumstances where an insured who has no credit for prior disability coverages (as described in Insurance Law Section 3234(a)(1)) is healthy enough to be hired but has a pre-existing condition that leads to her total disability during the policy's pre-existing condition waiting period, and where the policy also includes an “elimination period.” To treat these periods as running consecutively would create the possibility of extremely long periods of time during which a disabled insured would receive no benefits.

All elimination periods should be construed to run from the first date of the disability, rather than upon expiration of the pre-existing condition waiting period. Payment of benefits therefore should begin upon expiration of the elimination period, subject to the pre-existing condition waiting period. If the pre-existing condition waiting period has been satisfied, then payment of benefits should begin upon expiration of the elimination period. In cases where the elimination period has been satisfied and the pre-existing condition waiting period has not been satisfied, payment of benefits should begin on the first day of the month following the expiration of the pre-existing condition waiting period.

9. Form definition of “hospital” must comply with Section 52.2(m) of Regulation 62.
10. Form definitions of “injuries”, “sickness”, “first manifest”, “first diagnosed”, “first 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.
11. 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 example, “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 will consider other definitions.

12. 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 – 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 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”. Lifetime maximum benefit periods may be accepted, subject to rate clearance.

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 a period of time 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.

13. 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.
14. 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.
15. 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.
16. 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.
17. 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.

18. 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. The provision as drafted should be constructed to aid the insured in returning to work. Mandatory rehabilitation provisions are permitted so long as there is adequate disclosure in the form.
19. 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.
20. 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.

21. 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. Insurers may offset sums received by the insured due to workers' compensation or other similar plans. See Section 52.16(c)(8) of Regulation 62.
22. The benefits included in a disability income insurance policy should be designed in accordance with §§3201(c)(3) and 3217(b)(5), and 11 NYCRR 52.1(c) and 52.8. All benefits must be of real economic value and may not be designed to play upon one's fears of particular illnesses, conditions or injuries. Nor may the coverage be so complex or limited

that it does not expand consumer options for coverage, but instead serves only to confuse consumers.

The Department urges insurers to increase the overall insurance benefit, rather than creating additional benefits that have a lower probability of use for the insured. Any increase in benefits is paid for by an increase in premiums paid by the insured. Increasing the premium for a benefit that is highly unlikely to be of any advantage for the insured, is not economically valuable for the insured and thus is contrary to the intent of the Regulation. A benefit should decrease costs related to health care treatment for the average consumer and must provide a benefit of true economic worth.

However, the Department recognizes that changes in the market have created the desire to offer benefits not contained in competitors' policies, in order to entice consumers. The following are categories and examples of benefits for which companies have sought and received approval for inclusion in the past:

- a. Contribution. (COLA, 401(k), Pension) – Benefit paid as employee/insured's contribution while the insured cannot work or an additional benefit paid after the insured satisfies the waiting period.
- b. Education. (child education, spousal retraining) – benefit to defray the cost of education while the insured cannot work, as long as a general benefit is provided as a substitute.

Ex. We will pay a Higher Education Benefit if all of the following requirements are met:

1. You and your children are insured under the group policy.
2. You become disabled under the terms of the policy.
3. On the date of your disability, the child is either registered and in full-time attendance at an accredited institution of higher education beyond high school or the child is in the last year of high school before graduation and within one year is registered and in full-time attendance at an accredited institution of higher education beyond high school.

The Higher Education Benefit will be paid annually to each child who meets the requirement of item 3 above for a maximum of [2-6] years in a period of [3-8] consecutive years beginning on the date of your disability.

If you have no children or your children are not insured under the group policy, or your child does not meet the requirements of 3 above, then no Higher Education Benefit will be paid. The Alternate Higher Education Benefit of [\$100 - \$1000] will be paid in its place.

- c. Family care. (child care, family member care, parental care) – benefit to pay for the care of a child or family member while the insured's disability prevents him/her from caring for the individual.

Ex. We will pay a child care benefit if all of the following requirements are met:

1. You and your dependents are insured under the group policy.
2. You become disabled under the terms of the policy.

3. Your spouse pays a licensed child care provider who is not a member of your family for child care provided to your children under age [8-18] within [6-60] months of your becoming disabled.
 4. The child care is necessary in order for your spouse to work or to obtain training for work or to increase earnings.
- d. Therapy. (rehabilitation, bereavement, special counseling) – benefit paid for mental and emotional counseling following an accident or to persuade an insured to participate in a physical rehabilitation program with the purpose of helping the insured return to work sooner.

Ex. We may provide vocational rehabilitation services to help you return to work to the extent of your ability. If, after review of your claim, we determine that rehabilitation services are appropriate, we may provide, at our discretion, the following services:

1. Vocational evaluation to determine how your injury may impact your ability to work in your own occupation or another job or occupation.
2. Job placement services including resume preparation services and training in job seeking skills.
3. Alternative treatment plans such as recommendations for support groups, physical therapy, occupational therapy, or other treatment designed to enhance your ability to work

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(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.
10. 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.
11. 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.
12. Group 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.
13. 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.
14. 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.
15. 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. Rating Procedures and Requirements (excluding Disability Policies under the New York Disability Benefits Law)

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. Sections 52.40(e) and (f) of Regulation 62 set forth requirements for rate filing including rate manual and Actuarial Memorandum regarding rate development, applicable to group disability income forms.
4. Section 52.41 of Regulation 62 sets forth gross premium differentials based on sex which apply to group disability income forms.
5. Section 52.45 of Regulation 62 sets forth minimum loss ratio standards which apply to group disability income forms.