

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Group Specified Disease Coverage Checklist for SERFF Filings (As of 9/11/12) Non-Recurring (Lump Sum)

Instructions for SERFF Checklist:

- A. For **ALL** filings, the “General Requirements for All Filings” and the “Review of Product Outline” sections **MUST** be completed.
- B. For a **FORM** filing, completion of additional sections may be required as follows depending on the type of form being submitted:
 - Policy – Also complete the “Policy Form” section.
 - Rider or endorsement – Also complete all items in the “Policy Form” section relevant to the form being submitted.
 - Application – Also complete the “Application Forms” section.
- C. For filing of **RATES** for **NEW products**, complete the “New Products – Rate Requirements” section in addition to completion of the applicable form sections identified above. For filing of **RATE changes to EXISTING products** (increases, decreases, or change in rate calculation rules or procedures), complete the “Existing Products-Rate Requirements” section. For filing of **any OTHER changes to RATE or underwriting manuals** (e.g., changes in commissions or underwriting), complete the “Existing Products-Rate Requirements” section.
- D. For each item, enter in the last column the form number(s), page number(s) and paragraph(s) where the requirement is met in the filing or insert a bookmark connecting to the appropriate location in the filing. All items with shaded boxes must be answered.
- E. Do **not** make any changes or revisions to this checklist.
- F. **Instructions for Citations:** All citations to Department of Financial Services regulations link to the Department of State’s website and an unofficial copy of the NYCRR. Please select title 11 for Department of Financial Services regulations. Most of the pertinent form and rate regulations are located in Chapter III Policy and Certificate Provisions, Subchapter A Life, Accident and Health Insurance. All citations to New York Laws (Insurance Laws or other New York laws) link to the public LRS website. To locate the Insurance Laws, please select the link labeled “ISC”.

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES
REVIEW STANDARDS FOR GROUP SPECIFIED DISEASE COVERAGE
NON-RECURRING (LUMP SUM)

LINE OF BUSINESS: ~~Individual Health-Specified Disease-Limited Benefit~~
(Non-Recurring)

LINE(S) OF INSURANCE

CODES

CODE: **H07G**

Critical Illness

H07G.001

IF CHECKLIST IS NOT APPLICABLE, PLEASE EXPLAIN:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
GENERAL REQUIREMENTS FOR ALL FILINGS			Form/Page/Para Reference
FILING SUBMISSION			
Complete Policy Submission or Pages/Rider/Endorsement		<p>If this submission contains insert pages, riders or endorsements, then the policy in its entirety complies with all the statutory and regulatory provisions stated below.</p> <p><input type="checkbox"/> Yes This rider, insert pages, or endorsements are being attached to a policy that was approved by the Department on _____, submission number _____.</p> <p><input type="checkbox"/> No Explain in the last column.</p>	
Form Requirements	11 NYCRR 52.31 §3102(c)(1)(G)	<p>Each form in the filing must meet the following requirements:</p> <p>a. The provisions of this form are <u>not</u> misleading or unreasonably confusing. §3217(b)(2), §52.1(c).</p> <p>b. The provisions of this form provide substantial economic value to the policyholder. §3217(b)(5), §52.1(c).</p> <p>c. The provisions of this form are <u>not</u> unjust, unfair, inequitable, misleading, or deceptive to the policyholder. §§3201(c)(3), 3217(b).</p> <p>d. This form contains no strikeouts. §52.31(b).</p> <p>e. All blank spaces are filled in with hypothetical data. §52.31(f).</p> <p>f. If the form contains more than 3 pages or more than 3,000 words, the form contains a table of contents. §3102(c)(1)(G).</p> <p>g. If the form contains variable material, the form contains minimal variable material and a full explanation of the nature and scope of the variable material is attached in the filing. §52.31(k).</p> <p>h. Explanations of variable material must contain the alternative language and should not</p>	

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		state that the variations will “conform to law” or will be “as requested by the policyholder”. §52.31(l).	
Discrimination	§2606, §2607, & §2608	Unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, and marital status are prohibited.	
Flesch Score	§3102(c)	Provide Flesch score certification (the Flesch score should be at least 45). The number of words, sentences and syllables in the form should be set forth as part of the certification, which must be signed by an officer of the company.	
Group Status	§ 4235 §3201(b)(1) 11 NYCRR Part 59	<p>The submission letter should include a statement that policy forms will be sold to a group specified in Insurance Law §4235(c)(1). However, a more detailed statement must be included where discretionary group status is sought under Insurance Law §4235(c)(1)(M). See below. If the Standard Transmittal Form is submitted in lieu of the submission letter, all information regarding the group for which the submission is made, should be completed. The size of the group should be indicated (small, large or both). The letter should indicate whether the submission is for general use or is submitted on a one case basis. If the submission is for use on a one case basis, the group must be identified along with the subpart of Insurance Law §4235(c)(1) in which the group fits and a confirmation that the group meets all of the requirements of the identified subpart.</p> <p>Requests for discretionary group recognition, pursuant to Insurance Law §4235(c)(1)(M), must be accompanied by written documentation that demonstrates that the proposed group meets each and every element stated in the named statute. The documentation must also make clear that the request for discretionary group recognition is not a subterfuge, evasion technique, or a marketing tool to avoid compliance with other statutory or regulatory requirements and recognized marketing mechanisms. This provision is not intended to allow approval of groups recognized in the various subparagraphs of §4235(c)(1) or §4237(a)(3), but for which the proposed discretionary group does not meet one or more of the requisites specifically required or proscribed by §4235 or §4237. The request for allowance of a discretionary group must be granted before it may be used.</p> <p>Pursuant to §3201(b)(1) and Insurance Regulation 123, an accident and health certificate is deemed delivered in New York and subject to review and approval regardless of the actual place of delivery, if the policy is issued to certain groups. In these cases, the group certificate is reviewed for compliance with New York Law. The group policy that is delivered out-of-state is not reviewed.</p>	

CONSUMER INFORMATION			
Required Disclosure Form	11 NYCRR 52.15(b)(5) 11 NYCRR 52.66	<p>This filing contains the required disclosure form per §§52.15(b)(5) and 52.66 of Regulation 62 to be delivered to the applicant at the time application is made and receipt is acknowledged.</p> <p><i>Note: Two formats exist – one for persons under age 65 and one for persons age 65 or older. Direct response insurers will deliver the required disclosure form at the time the policy is delivered.</i></p>	

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APPLICATION FORMS			Form/Page/Para Reference
Authorization	11 NYCRR 420.18(b)	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.	
Extra-Hazardous Activities	11 NYCRR 52.2(i) 11 NYCRR 52.16(e)(2)	<p>If the application contains questions as to whether the applicant has engaged in or contemplates participation in a number of specified activities, the insurer will adhere to the following Regulation 62 guidelines regarding “extra-hazardous” activities:</p> <p>The Department permits an insurer to exercise a number of options depending upon whether or not the activity engaged in by the applicant is an extra-hazardous activity as defined by the Department in §§52.2(i) and 52.16(e)(2). If the activity engaged in by the applicant is <u>within</u> the Department’s definition of an extra-hazardous activity, the insurer may elect one of four options:</p> <ol style="list-style-type: none"> The insurer may issue a standard risk policy; The insurer may decline to issue any policy at all; The insurer may place a waiver on the policy declining coverage for disabilities arising out of such activities; or The insurer may charge additional premiums for providing coverage for such activities. <p>If the activity engaged in is <u>not within</u> the definition of an extra-hazardous activity, the Department permits the insurer to issue a standard risk policy or decline to issue any policy at all.</p>	
Fraud Warning Statement	§403(d)	All applications must contain the prescribed fraud warning statement.	
Health Questions	11 NYCRR 52.51(b)	Any question of 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.” <i>Note: Does not apply to questions about factual information such as doctor visits or hospital confinements.</i>	
Investigative Consumer Report	§380-c of the General Business Law	If an Investigative Consumer Report will be prepared or procured, a notice complying with §380-c of the General Business Law is included in the application <u>or</u> in a separate form.	
Medical Information Exchange Center	§321	If a Medical Information Exchange Center (such as a Medical Information Bureau) will be used, the insurer complies with §321 of the Insurance Law.	
Multiple Applications for One Policy	§4224(b)	If more than one application is used to apply for a policy, attach a full explanation of the objective criteria used to determine who completes each application. <i>Note: Objective criteria are necessary to avoid unfair discrimination.</i>	
Multiple Levels of Underwriting	§4224(b)	<p>If more than one level of medical and financial underwriting (e.g., full underwriting, simplified underwriting, or guaranteed issue) is used for a policy, attach a full explanation of:</p> <ol style="list-style-type: none"> The various levels of underwriting. The objective criteria used to determine the use of each level of underwriting. 	
Overinsurance	11 NYCRR 52.15(b)(15)(i) 11 NYCRR 52.15(b)(15)(ii)	<p>The application includes questions to:</p> <ol style="list-style-type: none"> Elicit whether, as of the date of the application, the applicant has coverage in force or application(s) pending for another specified disease policy or certificate for the <u>same</u> 	

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		specified disease <u>with the same or a different insurer</u> . §52.15(b)(15)(i). b. Elicit the <u>number</u> of specified diseases for which either the applicant has coverage in force as of the date of the application <u>or</u> application(s) pending as of the date of the application. §52.15(b)(15)(ii).	
Pre-Existing Conditions	11 NYCRR 52.51(i)	If the application is used with a policy that contains a “pre-existing conditions” provision, a statement describing the policy provision is included in the application.	
Prohibited Questions and Provisions	11 NYCRR 52.51 §3204	The application does <u>not</u> contain: a. Questions as to the applicant’s race. b. A provision that changes the terms of the policy to which it is attached. c. A statement that the applicant has not withheld any information or concealed any facts. d. An agreement that an untrue or false answer material to the risk will render the contract void. e. 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 insured in the application, except to conform to §3204. f. A question or seek previous HIV test results. <i>Note: 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.</i>	
Telephone or In-Person Interview	§3204 Article III, NY Technology Law	If a telephone or in-person interview will be used with this application, the interview is conducted in the following manner: a. Any questions raised during the interview are limited to those questions appearing on an application approved by the Department (i.e., questions over the phone would be no different than those being asked in the application). b. The applicant must be provided with a written copy and will have an opportunity to review and make corrections to those statements that were attributed to him/her in the interview. c. Any information obtained in the interview that will be used in the underwriting process will be reduced to writing, signed by the applicant and <u>attached</u> to the policy in compliance with §3204. d. If an electronic signature is used, it must comply with the Electronic Signatures and Records Act (Article III of the New York Technology Law). e. If a telephonic application is being used, please provide a description of the procedure for taking a telephonic application. Any scripts used in the telephone interview must be filed for reference.	
Underlying Health Coverage	11 NYCRR 52.15(b)(13)	The application includes a question that elicits whether the applicant has <u>at least</u> major medical or <u>at least</u> basic hospital and basic medical in force on the date of the application.	
CONDITIONAL RECEIPT/INTERIM INSURANCE AGREEMENT FORM			
Advance Premium	11 NYCRR 52.53	If premium will be taken at the time of application, the filing should include a conditional receipt OR interim insurance agreement that complies with §52.53 of Regulation 62. (E.g., cannot use a hybrid receipt or agreement which is less favorable than §52.53)	

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		requirements). See product outline for brief summary of requirements.	
POLICY FORM	§3102 , §3105 , §3201 , §3204 , §3216 & 11 NYCRR Part 52 (Reg. 62)		Form/Page/Para Reference
COVER PAGE			
Label	11 NYCRR 52.15	Policy is labeled as “Specified Disease Coverage” within the definition of §52.15.	
Licensee		The licensed New York insurer’s name and full address appears prominently on the front or back cover.	
Limited Policy Statement	11 NYCRR 52.15(b)(9)	The cover page contains the statement required by §52.15(b)(9).	
Medicare Notice	11 NYCRR 52.18(a)(7) 11 NYCRR 52.66	If the policy is sold to persons eligible for Medicare (due to age or disability), a notice complying with §52.18(a)(7) is included either on the cover page of the policy <u>or</u> the first page of the disclosure statement required by §52.66.	
Signature of Company Officer		The signature of company officer(s) appears prominently on the form (such as on the cover).	
DEFINITIONS			
Hospital	11 NYCRR 52.2(m)	The definition of “Hospital” complies with §52.2(m).	
Mental Disorders	§3201(c)(3) , §3217(b) , §4224(b)(2) 11 NYCRR 52.1(c) 11 NYCRR 52.1(d) 11 NYCRR 52.16(c)(2)	The definition of “Mental Disorders” or a similar term complies with §§3201(c)(3), 3217(b), 4224(b)(2), 52.1(c), 52.1(d), and 52.16(c)(2).	
Physician	§3201(c)(3) , §3217(b) , 11 NYCRR 52.1(c) 11 NYCRR 52.1(d) 11 NYCRR 52.15	The definition of “Physician” or any substitute term includes any legally qualified practitioner of the healing arts acting within the scope of his/her New York State license. (i.e., chiropractor, licensed social worker, etc.) <i>Note: Form should not unduly limit the insured’s access to benefits.</i>	
Pre-existing Condition	11 NYCRR 52.15(b)(6)	The definition of “Pre-existing Condition” complies with §52.15(b)(6).	
Specified Disease Coverage	11 NYCRR 52.15(a)	The definition of “Specified Disease Coverage” complies with § 52.15(a).	
FORM PROVISIONS			
Arbitration	§3216(d)(1)(K)	The form does <u>not</u> provide for mandatory arbitration.	
Assignment	§3201(c)(3) , §3216(d)(1)(L) , §3217(b) 11 NYCRR 52.15	If the form contains an assignment provision, it complies with §§3201(c)(3), 3216(d)(1)(L), 3217(b), and 52.15.	
Dependent Coverage	§4235(f) , 11 NYCRR 52.18(e) Circular Letter No. 27 (2008)	If dependents are covered under this form such coverage is in compliance with §§4235(f) and 52.18(e). This includes the recognition of marriages between same-sex partners legally performed in other jurisdictions.	
Military Suspension	§3221(n) §3221(o) §52.18(e)(3) Circular Letter No. 7 (2003)	Suspension provision for insureds called to active duty in the armed forces complies with §§3221(n), 3221(o), and 52.18(e)(3).	

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Refund of Premium upon Death	§3228	This form provides for a refund of premium upon death per §3228.	
Waiver of Premium	§3201(c)(3) §3217(b) 11 NYCRR 52.1(c) 11 NYCRR 52.1(d) 11 NYCRR 52.15 11 NYCRR 52.16(b)	If the form contains a provision for waiver of premium during a period of sickness, it complies with §§3201(c)(3), 3217(b), 52.1(c), 52.1(d), 52.15, and 52.16(b).	
SPECIFIED DISEASE REQUIREMENTS			
Benefit Offset	11 NYCRR 52.15(b)(4)	Benefits for specified disease coverage will be paid regardless of other coverage, except for any policy provision regarding other insurance with the insurer providing specified disease coverage. <i>Note: §3216(d)(2)(C) of the Insurance Law sets forth the optional standard provision for “Other Insurance in This Insurer.”</i>	
Covered Benefits	11 NYCRR 52.15	<p>a. The form contains ONLY benefits related to specified disease coverage as defined in §52.15(a). It does <u>not</u> contain any benefits unrelated to specified disease coverage (i.e., categories defined in Regulation 62 other than §52.15).</p> <p>b. <u>All forms</u> of the specified disease or diseases are covered. §52.15(b)(1).</p>	
Diagnosis	11 NYCRR 52.15(b)	<p>a. If the filing uses the term “first diagnosis,” “first treatment,” “first manifested,” or a similar term, such term(s) will be administered in compliance with §52.15(b)(6).</p> <p>b. If the form conditions benefit payment on pathological diagnosis of a covered disease:</p> <ul style="list-style-type: none"> The form provides that, if such a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead. The form provides that <u>any</u> type of medically appropriate diagnosis will be accepted. §52.15(b)(2). 	
Overinsurance	11 NYCRR 52.15(b)(8)	<p>This filing contains the insurer’s overinsurance rules. Overinsurance exists when:</p> <ul style="list-style-type: none"> An insured has more than one specified disease policy for the <u>same</u> specified disease, regardless of the insurer, <u>or</u> A policy is issued to any person that results in that person becoming covered by <u>8 or more</u> specified diseases. <i>Note: Maximum number of specified diseases for which an individual may be covered is 7, regardless of the number of insurers.</i> 	
Reduction in Benefits	11 NYCRR 52.15(b)(16)	The form does <u>not</u> contain a reduction in specified disease benefits (e.g., when certain events occur or ages are reached).	
Underlying Coverage	11 NYCRR 52.5 11 NYCRR 52.6 11 NYCRR 52.7 11 NYCRR 52.15(b)(12)	<p>Specified disease coverage will <u>only</u> be issued to persons covered by either <u>at least</u> major medical insurance (defined in §52.7) or <u>at least</u> basic hospital insurance and basic medical insurance (defined in §§52.5 and 52.6). §52.15(b)(12)</p> <p>Within 30 days after policy delivery, the insurer will ask the insured person(s) in a written request whether the insured person(s) has in force <u>at least</u> major medical insurance or <u>at least</u> basic hospital insurance and basic medical insurance on the effective date of the specified disease coverage. If an insured responds that the underlying coverage is not in force on the effective date of the specified disease coverage, the policy will be voided from its beginning with a full premium refund. §52.15(b)(14). <i>Note: Attach an explanation</i></p>	

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		<i>of the method by which the insurer will implement these requirements. See outline for details.</i>	
INDEMNITY AND NON-RECURRING SPECIFIED DISEASE REQUIREMENTS		<i>Note: An example of Indemnity and Non-Recurring basis is payment of a lump sum benefit upon diagnosis. (If the form benefits are conditioned on ongoing treatment, use the checklist and outline for Recurring coverage instead.)</i>	
Benefits Payable	11 NYCRR 52.15(d)	<p>a. Benefits will always be payable upon initial and medically appropriate diagnosis of the specified disease covered by the policy subject to the probationary period allowed in §52.15(d)(2). <i>Note: "Initial" refers to while the policy is in force.</i></p> <p>b. The policy clearly specifies the criteria to be satisfied in order to trigger the payment of benefits. §52.15(d)(6).</p>	
Design	11 NYCRR 52.15(d)	<p>The policy (and any riders) has been designed as a §52.15(d) non-recurring (lump sum) specified disease policy and not as a §52.15(c) recurring specified disease policy. <i>Note: If not designed under §52.15(d) only, attach an explanation as to how the form meets requirements of both and why the design is not prohibited by the overinsurance rules.</i></p>	
Dollar Benefits	11 NYCRR 52.15(d)(1)	<p>Dollar benefits are offered only in even increments of \$1,000 and do not exceed \$500,000.</p> <p>If Dollar benefits are <u>less than \$1,000</u>, the following requirements must be met:</p> <p>a. The dollar benefit is <u>not</u> less than \$250.</p> <p>b. The provision clearly indicates that this lower benefit applies to a clearly identifiable form of a disease with significantly lower treatment costs.</p> <p>c. Attach an opinion statement from a medical professional verifying that this is a clearly identifiable form of the disease with significantly lower treatment costs.</p>	
Maximum Policy Benefit	11 NYCRR 52.15(d)(5)	Benefit amounts payable for any one specified disease are subject to a maximum policy benefit for all specified diseases covered under the policy.	
Payment of Indemnity Amounts	11 NYCRR 52.15(d)(3)	<p>If indemnity amounts for any one specified disease will be paid in more than two <u>equal installments</u>, benefits will not be paid for:</p> <p>a. Any reoccurrence or spread of the same specified disease,</p> <p>b. A new primary occurrence of the same specified disease, <u>or</u></p> <p>c. The resulting death of the insured due to the same specified disease. §52.15(d)(3).</p>	
Probationary Period	11 NYCRR 52.15(d)	<p>If the form contains a probationary period:</p> <p>a. The probationary period is no more than 30 days from the coverage effective date. §§52.15(d)(2), 52.16(d)(1).</p> <p>b. During the probationary period, the insurer may void the policy from its beginning with a full premium refund to the insured for a specified disease diagnosed within the initial 30 days of coverage. §52.15(d)(2)</p> <p>A new probationary period for any one specified disease is <u>not</u> instituted for:</p> <p>a. Any recurrence or spread of the same specified disease, <u>or</u></p> <p>b. A new primary occurrence of the same specified disease. §52.15(d)(4).</p>	
MANDATORY STANDARD PROVISIONS		<i>Note: These provisions <u>must</u> be included in each policy. The provision must be no less favorable to the insured than the statutory provision.</i>	
Change of Beneficiary	§4235(e)	When applicable, this provision must be included but must be no less favorable to the	

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		insured than the statutory provision.	
Claim Forms	§3221(a)(10)	This provision must be included and must be no less favorable to the insured than the statutory provision.	
Grace Period	§3221(a)(4)	The policy may contain a period of grace as specified therein.	
Legal Actions	§3221(a)(14)	The policy must provide that no action in law or equity shall be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought after the expiration of two years following the time such proof of loss is required by the policy.	
Certificates	§3221(a)(6)	The insurer must issue a certificate in compliance with §3221(a)(6).	
Eligible Class	§3221(a)(3)	This provision must be included and must be no less favorable to the insured than the statutory provision.	
Loss of Life	§3221(a)(13)	When applicable, this provision must be included but must be no less favorable to the insured than the statutory provision.	
Non-Renewal	§3221(a)(5)	Conditions under which an insurer may decline renewal must be set forth in the policy.	
Notice of Claim	§3221(a)(8)	The policy must provide that the insured has a minimum of 20 days to provide the insurer with written notice of claim. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	
Payment of Claims	§3221(a)(12)	This provision must be included and must be no less favorable to the insured than the statutory provision.	
Physical Examinations and Autopsy	§3221(a)(11)	The insurer shall have the right and opportunity to examine the insured making a claim as required during the pendency of the claim and the right and opportunity to conduct an autopsy in the case of death unless prohibited by law.	
Policy Changes	§3221(a)(2)	This provision must be included and must be no less favorable to the insured than the statutory provision.	
Proofs of Loss	§3221(a)(9)	The policy must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	
Statements of Insured	§3221(a)(1)	The policy must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	
Unilateral Modification	11 NYCRR 52.18(a)(8)	Unilateral modifications by an insurer to an existing policy must be made with at least 30 days prior written notice to the policyholder. Unilateral modification by the insurer may be made only at the time of renewal. A contractual requirement to provide prior written termination requires at least 14 days notice. If the policy requires the policy holder to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to such policy holder no less than 14 days prior to the date by which the policy holder is required to provide notice to terminate coverage.	
Notice of Termination	11 NYCRR 52.18(c)	Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	
OPTIONAL STANDARD PROVISIONS		<i>These provisions may be included at the insurer's option.</i>	
Benefit Offsets	11 NYCRR 52.18(d)	If the insurer wishes to offset the benefits they must comply with this provision.	

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Illegal Occupation	§3216(d)(2)(J)	If this provision is included, it must comply with the standard provision language of the statutory provision and may <u>not</u> be less favorable in any respect to the insured.	
Intoxicants and Narcotics	§3216(d)(2)(K)	If this provision is included, it must comply with the standard provision language of the statutory provision and may <u>not</u> be less favorable in any respect to the insured.	
Subrogation	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a)	If a subrogation provision is included in this policy or certificate, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a)	
Wellness Programs	§3239	<p>Wellness programs are permitted and are defined as programs designed to promote health and prevent disease that may contain rewards and incentives for participation. A wellness program may include but is not limited to: the use of a health risk assessment tool; a smoking cessation program; a weight management program; a stress management program; a worker injury prevention program; a nutrition education program; and a health or fitness incentive program. A wellness program may use rewards and incentives for participation provided that where the group health insurance policy or subscriber contract is required to be community-rated, the rewards and incentives shall not include a discounted premium rate or a rebate or refund of premium.</p> <p>Permissible rewards and incentives include: full or partial reimbursement of the cost of participating in smoking cessation or weight management programs; full or partial reimbursement of the cost of membership in a health club or fitness center; the waiver or reduction of copayments, coinsurance and deductibles for preventive services covered under the group policy or subscriber contract; and monetary rewards in the form of gift cards or gift certificates, so long as the recipient of the reward is encouraged to use the reward for a product or a service that promotes good health, such as healthy cook books, over the counter vitamins or exercise equipment.</p> <p>Participation in the wellness program must be available to similarly situated members of the group and must be voluntary on the part of the member. The terms of the wellness program must be set forth in the policy or contract.</p>	
PERMISSIBLE EXCLUSIONS & LIMITATIONS			
Alcoholism and Drug Addiction	11 NYCRR 52.16(c)(2) §3216(d)(2)(K)	If an insurer chooses to place an exclusion or limitation on coverage for treatment arising out alcoholism or drug addiction, it must comply with §§52.16(c)(2) and 3216 (d)(2)(K) as pertinent.	
Cause of Illness, Treatment, or Medical Condition	11 NYCRR 52.16(c)(4) §3216(d)(2)(J)	<p>If an insurer chooses to place an exclusion or limitation on coverage for illness, treatment, or medical condition arising out of the following situations, it must comply with §52.16(c)(4):</p> <ol style="list-style-type: none"> war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; (<i>Note: For felony participation, see also §3216(d)(2)(J)</i>) service in the armed forces or units auxiliary thereto; suicide, attempted suicide, or intentionally self-inflicted injury (<i>Note: No distinction is made for sane or insane</i>); or 	

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		e. aviation (this exclusion applies only to nonfare paying passengers).	
Chiropractic Care	11 NYCRR 52.16(c)(7)	If an insurer chooses to place an exclusion or limitation on structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference, it must comply with §52.16(c)(7).	
Cosmetic Surgery	11 NYCRR 52.16(c)(5)	If an insurer chooses to place an exclusion or limitation on cosmetic surgery, it must comply with §52.16(c)(5).	
Custodial Care	11 NYCRR 52.16(c)(11)	If an insurer chooses to place an exclusion or limitation on rest cures and custodial care, it must comply with §52.16(c)(11).	
Dental	11 NYCRR 52.16(c)(9)	If an insurer chooses to place an exclusion or limitation on dental care or treatment, it must comply with §52.16(c)(9).	
Eyeglasses, Hearing Aids, and Exams	11 NYCRR 52.16(c)(10)	If an insurer chooses to place an exclusion or limitation on eyeglasses, hearing aids, and exams, it must comply with §52.16(c)(10).	
Family Provider	11 NYCRR 52.16(c)(8)	If an insurer chooses to place an exclusion or limitation on services provided by a member of the covered person's immediate family, it must comply with §52.16(c)(8).	
Foot care	11 NYCRR 52.16(c)(6)	If an insurer chooses to place an exclusion or limitation on foot care, it must comply with §52.16(c)(6).	
Government Facility	11 NYCRR 52.16(c)(8)	If an insurer chooses to place an exclusion or limitation on treatment provided in a government facility (unless otherwise required by law), it must comply with §52.16(c)(8).	
Mandatory No-Fault	11 NYCRR 52.16(c)(8)	If an insurer chooses to place an exclusion or limitation on services for which benefits are provided by any mandatory motor vehicle no-fault law, it must comply with §52.16(c)(8). Note: The term "provided" is permitted, not "payable" or "reimbursable."	
Medicare or Other Governmental Program	11 NYCRR 52.16(c)(8)	If an insurer chooses to place an exclusion or limitation on services for which benefits are provided by Medicare or other governmental program (except Medicaid), it must comply with §52.16(c)(8). Note: The term "provided" is permitted, not "payable" or "reimbursable."	
Mental or Emotional Disorders	11 NYCRR 52.16(c)(2)	If an insurer chooses to place an exclusion or limitation on coverage for mental or emotional disorders, it must comply with §52.16(c)(2).	
Outside U.S. and Possessions	11 NYCRR 52.16(c)(12)	If an insurer chooses to place an exclusion or limitation on coverage while the insured is outside the United States and its possessions, it must comply with §52.16(c)(12). Note: <i>Must provide coverage within U.S., its possessions, Canada, and Mexico.</i>	
Pre-Existing Conditions	11 NYCRR 52.15(b)(6)	If an insurer chooses to place a pre-existing condition limitation in the coverage, it must comply with §52.15(b)(6). Note: <i>This is the only permissible pre-existing condition limit allowed for specified disease coverage.</i>	
Pregnancy	11 NYCRR 52.16(c)(3)	If an insurer chooses to place an exclusion or limitation on pregnancy, it must comply with §52.16(c)(3).	
Separate Billing	11 NYCRR 52.16(c)(8)	If an insurer chooses to place an exclusion or limitation on services rendered and separately billed by employees of hospitals, laboratories or other institutions, it must comply with §52.16(c)(8).	
Services for Which No Charge is Normally Made	11 NYCRR 52.16(c)(8)	If an insurer chooses to place an exclusion or limitation on services for which no charge is normally made in the absence of insurance, it must comply with §52.16(c)(8).	
Transportation	11 NYCRR 52.16(c)(11)	If an insurer chooses to place an exclusion or limitation on transportation, it must comply with §52.16(c)(11).	
Workers' Compensation	11 NYCRR 52.16(c)(8)	If an insurer chooses to place an exclusion or limitation on services for which benefits are provided by any state or federal workers' compensation, employer's liability or occupational disease law, it must comply with §52.16(c)(8). Note: The term "provided" is permitted, not	

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		"payable" or "reimbursable."	
RATE-RELATED INFORMATION			
Loss Ratio	11 NYCRR 52.45(j)(2)(iv)	The minimum loss ratio for the policy complies with 11 NYCRR52.45(j)(2)(iv) .	
Sex Basis for Rates	11 NYCRR 52.41	This form is rated on the following basis: (select only one) <input type="checkbox"/> Unisex basis, <u>or</u> <input type="checkbox"/> Sex-distinct basis and will <u>not</u> be issued in any employer/employee situation subject to the <i>Norris</i> decision and/or Title VII of the Civil Rights Act of 1964.	
SCHEDULE OF BENEFITS			
Benefit Selections	11 NYCRR 52.31(f) §3204 (a)(1)	The schedule page sets forth optional choices of insured regarding certain benefits and/or riders selected by the insured.	
Effective Date and Renewal Dates	11 NYCRR 52.31(f)	The schedule page includes spaces for effective date of insurance, renewal dates and renewal terms.	
Hypothetical Data	11 NYCRR 52.31(f)	The schedule page is completed with hypothetical data.	
Name of Insured	11 NYCRR 52.31(f)	The schedule page includes space for the insured's name.	
Premium Summary	11 NYCRR 52.31(f)	The schedule page contains premium summary amounts and provisions dealing with insured participation status in surplus or dividends.	
Varying Elements	11 NYCRR 52.15(d)(2) 11 NYCRR 52.31(f) §3204 (a)	The schedule page sets forth amounts payable for certain specified diseases, probationary period time provisions complying with §52.15(d)(2), and similar varying elements of the policy selected by the insured.	
REMINDERS		<ul style="list-style-type: none"> The company may only offer discounts that are submitted and acknowledged by the Health Bureau's Rating Section as justifiable discounts before being placed on file by the Rating Section. No advertisement of the policy will imply coverage beyond the terms of the policy. Synonymous terms will not be used to refer to any disease so as to imply broader coverage than is the fact. 11 NYCRR 52.12(b)(10). The insurer is obligated under §2611 of the Insurance Law and §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 3 (1989) and 5 (1997) are relevant. The insurer may make insertions to the application only for administrative purposes 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 pursuant to §3204. The insurer will <u>not</u> refuse to issue coverage, cancel coverage or decline to renew coverage because of the sex or marital status of the applicant or policyholder. §2607 of the Insurance Law. 	

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NEW PRODUCTS – RATE REQUIREMENTS	11 NYCRR 52.40(e)(1)	<p><i>Complete this section for all forms filings except those filings where a rate filing is unnecessary because: (select one)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> <i>The submission contains only application forms, disclosure statements, and/or advertising, <u>or</u></i> <input type="checkbox"/> <i>The submission is an out-of-state filing pursuant to Section 3201(b)(2), <u>or</u></i> <input type="checkbox"/> <i>The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</i> <p><i>(For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below instead.)</i></p>	Form/Page/Para Reference
ACTUARIAL MEMORANDUM	11 NYCRR 52.40(a)(1)	<p>Actuarial qualifications:</p> <ul style="list-style-type: none"> a. Member of the Society of Actuaries, and b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries. 	
Justification of Rates	11 NYCRR 52.40(e)(2)(ii)(b) 11 NYCRR 52.15(a) 11 NYCRR 52.15(b) 11 NYCRR 52.15(d)	<ul style="list-style-type: none"> a. Specific formulas and assumptions used in calculating rates b. Expected claim costs c. Actuarial justification for the use of claim costs and other assumptions d. Description of marketing methods e. Justification of gross premium differentials based on sex f. If occupational classifications exist, provide a description and actuarial justification g. Non-claim expense components as a percentage of gross premium 	
Loss Ratios	11 NYCRR 52.40(e)(2)(ii)(b) 11 NYCRR 52.45(i)(2)(iv)	Expected loss ratios by duration and in the aggregate – with actuarial justification	
Actuarial Certification	11 NYCRR 52.40(a)(1) 11 NYCRR Part 94	<ul style="list-style-type: none"> a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans” as adopted by the Actuarial Standards Board. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory. 	
Expected Loss Ratio Certification	11 NYCRR 52.45(i)(2)(iv)	The expected loss ratio is: %	
RATE MANUAL	11 NYCRR 52.40(e)(2)(i)	<ul style="list-style-type: none"> a. Table of Contents b. Rate pages c. Insurer name on each consecutively numbered rate page d. Identification by form number of each policy, rider, or endorsement to which the rates apply e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits f. Description of rating classes g. Examples of rate calculations h. Commission schedules i. Underwriting guidelines and/or underwriting manual j. Expected loss ratios 	

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EXISTING PRODUCTS – RATE REQUIREMENTS	11 NYCRR 52.40(e)(1)	<p><i>Complete this section for all filings of changes in rates (e.g., rate increases/decreases or changes in rate calculation rules or procedures), commissions or underwriting to existing products.</i></p> <p><i>(For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.)</i></p>	Form/Page/Para Reference
ACTUARIAL MEMORANDUM	11 NYCRR 52.40(a)(1)	<p>Actuarial qualifications:</p> <ul style="list-style-type: none"> a. Member of the Society of Actuaries; and b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries. 	
Justification of Rates	11 NYCRR 52.40(e)(2)(ii)(b) 11 NYCRR 52.15(a) 11 NYCRR 52.15(b) 11 NYCRR 52.15(d)	<ul style="list-style-type: none"> a. Description of benefits b. History of previous New York rate revisions. If nationwide experience is included per item (e) below, provide history of previous non-New York rate revisions as well. c. First and last years of issue d. Actual and expected loss ratios by duration e. Complete New York experience since inception. If New York experience is not credible, provide nationwide experience as well. <ul style="list-style-type: none"> (i) Yearly and in total (ii) All items except reserves accumulated with interest (accumulated from midpoint of calendar year to most recent Dec. 31) (iii) As in (i), but with premiums adjusted to the current New York rate schedule. Describe the basis for all reserves. f. Derivation of the proposed rate revision in detail, including demonstrations that: <ul style="list-style-type: none"> (i) The expected future loss ratio and expected lifetime loss ratio are at least as large as the disclosure loss ratio, and (ii) The expected future loss ratio is at least as large as the applicable minimum loss ratio per 11 NYCRR 52.45(j)(2)(iv). g. A statement that the rates when approved will be applied to all policies delivered or issued for delivery in New York State, regardless of place of current residence. 	
Actuarial Certification	11 NYCRR 52.40(a)(1) 11 NYCRR Part 94	<ul style="list-style-type: none"> a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans”. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory. 	
Expected Loss Ratio	11 NYCRR 52.45(j)(2)(iv)	The expected loss ratio is: %	
REVISED RATE MANUAL PAGES	11 NYCRR 52.40(e)(2)(i)	<ul style="list-style-type: none"> a. Table of Contents b. Rate pages c. Insurer name on each consecutively numbered rate page d. Identification by form number of each policy, rider or endorsement to which the rates apply e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits 	

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		<ul style="list-style-type: none">f. Description of rating classesg. Examples of rate calculationsh. Commission schedulesi. Underwriting guidelines and/or underwriting manualj. Expected loss ratio	
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