NEW YORK STATE
DEPARTMENT of
FINANCIAL SERVICES

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GROUP TERM LIFE INSURANCE OUTLINE
(Last Updated 7/11/2012)

This outline is current as of July 11, 2012. Subsequent changes to statutes, regulations, circular letters, etc., may not be reflected in the outline. In case of any doubt, please contact the Life Bureau.

GROUP TERM LIFE INSURANCE
(Last Updated 7/11/12)

I. Applicability

A. Scope

This product outline covers all group term life insurance policies and certificates delivered in this state and group life certificates deemed to be delivered in this state.

B. Certificate/Policy

For purposes of this outline, contract language required in the group policy is also required for group certificates, unless the content clearly indicates otherwise. In general, policy provisions that affect the rights and benefits of certificate holders must also be included in the group certificates. The Department has approved policies which incorporate the provisions of the attached certificates into the policies.

II. Filing Requirements

A. Overview

1. Prior Approval Requirement

Section 3201(b)(1) provides that no policy form shall be delivered or issued for delivery in this state unless it has been filed with and approved by the superintendent as conforming to the requirements of the Insurance Law (standard and generally applicable provisions) and not inconsistent with law (federal and state statutory, regulatory and decisional law).

2. Discretionary Authority For Disapproval

Section 3201(c)(1) and (2) permits the Superintendent to disapprove any policy form that contains provisions that are misleading, deceptive, unfair, unjust, or inequitable or if its issuance would be prejudicial to the interests of policyholders or members. See also §§ 2103, 3209, 4224, 4226, 4231,

Misleading or Deceptive Provisions. Section 3201(c)(1). See also Sections 4226, 2123, 3209.

Prejudicial to the Interests of Policyholders or Members. Section 3201(c)(2). See also Section 4216(c)(1) with respect to self-support.

Unjust, Unfair, Inequitable Provisions. Section 3201(c)(2). See also Sections 4224, 4231, 4239, 2403.

Contrary to Law or Public Policy. See also Sections 3207, 3208, 4213, 4214, 2611, and 2612.

Premium Unreasonable In Relation to Benefits. See Sections 3201(b)(1), 4216(b)(12), (13) and (14), 4216(e), Regulation 123.

B. Types of Policy Form Filings with the Life Bureau

1. Traditional Prior Approval

Section 3201(b)(1).

2. Prior Approval with Certification Procedure

Circular Letter No. 6 (2004) provides for an expedited approval procedure based on an appropriate certification of compliance signed by an officer of the company in the format provided by Circular Letter No. 6 (2004). Certifications that have been altered or otherwise modified will not be accepted. The original certification must be provided. The form number of each form and the memorandum of variable material for each form must be listed in the body of the certification rather than in an attached list.

The submission letters will need to comply with applicable circular letter and product outline guidance.

Substitution filings/follow-up correspondence with post-approval form changes requested prior to initial issuance of forms will not be permitted for Circular Letter No. 6 (2004) filings.

3. Alternative Approval Procedure (Deemer Submissions)

Section 3201(b)(6) and Circular Letter No. 2 (1998) provide for an expedited approval procedure designed to prevent delays by deeming forms to be approved or denied if the Department or insurer fails to act in a timely manner.

4. Accelerated Approval For Certificates Deemed To Be Delivered in New York

Section 3201(b)(1) and Section 59.6 of Regulation No. 123 provide for an accelerated approval procedure for certain certificates deemed to be delivered in New York in which a conditional approval will be granted in reliance upon the insurer's certification of full compliance with all applicable laws and regulations.

5. Prefiled Insurance Coverage

Circular Letter 64-1 establishes the conditions and procedures under which insurers may provide or assume risk for group life coverage prior to the filing or approval of policy forms. The conditions include the following:

(a) Immediate coverage requested to meet specific need of policyholder.

(b) Insurer has reasonable expectation of approval or acceptance for filing.

(c) Confirmation letter sent to policyholder by the insurer stating:

  (i) the nature and extent of benefits or change in benefits;

  (ii) that the forms may be executed and issued for delivery only after filing with or approval by the department;

  (iii) an understanding that, if such forms are not filed or approved or are disapproved, the parties will be returned to status quo insofar as possible, or the coverage will be modified retroactively to meet all requirements necessary for approval; and

(d) Department notification.

(i) A statement explaining the circumstances and reasons for delay in submitting forms must be submitted within nine months for group life insurance. As a best practice, we recommend providing a copy of confirmation letter within 30 days of the agreement to provide insurance.

(ii) A follow-up statement must be submitted every six months until the form is submitted. If the reason for the delay is unacceptable, the Department may pursue a violation under Section 4241 for willful violation of the prior approval requirement.

(e) Forms must be submitted within nine months for group life subject to extension with satisfactory explanation for delay.

6. Filing of non-English versions of forms

(a) The English version of the form must be approved before the non-English version can be approved. The submission letter must identify, by form number, date of approval and Department file number, the previously approved form that is being translated into a non-English version.

(b) The non-English version must have a different form number to distinguish it from the English version. (For example, the Spanish version of form APP-123 could be APP-123-S.)

(c) An original certification by a translator must be provided indicating that the text of the form is an accurate and complete translation of the English version of the form. The certification must reference the specific form numbers of both the English and non-English forms and must reference the memorandum of variable material. The certification should not use qualifying language such as "to the best of my knowledge and belief".

(d) An original certification by an officer of the company must be provided indicating that the officer has exercised due diligence in choosing a competent translator or translation service. The certification must reference the specific form numbers of both the English and non-English forms. Section 3102(b)(3).

(e) If the approval of the English version of the form was subject to any conditions or limitations, then the non-English language version of the form will be subject to the same conditions or limitations.

(f) If the non-English version of the form contains variable material, a memorandum of variable material must be provided. The exact language of any non-English alternate text must be set forth.

C. Policy Form Submission Rules

1. Preparation of Forms for Submission.

(a) Basic Rules - See Circular Letters 1963-4, 1963-6 and 1969-4. References are to Circular letter 6 (1963), unless otherwise indicated.

(b) Each policy form should be designated with form number on lower left-hand corner of face page. § I.D.

(i) Distinguishes the form from all others of the insurer.

(ii) We object to a company's use of the matrix approach that identifies benefit provisions within a document with separate form numbers.

(c) Submit duplicate copies of the forms and any memorandum of variable material.§ I.G. and I.E.7.

(d) Printed forms should be used unless its use is too limited to justify printing. The form should be clear, legible and reasonably permanent. § I.F.1. Computer-generated forms are acceptable. See also readability provision Section 3102.

(e) Blank spaces in forms (other than application forms) should be filled in and completed with hypothetical data to indicate purpose and use of forms. In the alternative, the submission letter should explain purpose and use of each form submitted for review. §I.E.1.

(f) All incorporations by reference should be attached to the forms and submitted for approval or if previously approved, accompany the submission. See Sections 3204 and 3201 and Circular Letter 1963-4 Guidelines for Examination of Group Life Forms § I. B.12.

(g) The application (or enrollment form), regardless of whether it will be attached to policy, should be submitted. If previously approved, the form or submission letter should so indicate (with Department file number, form number and approval date). § I.E.4.

(h) All endorsements to be applied by stamp should be submitted, with separate form number, on company letterhead for prior approval. § I.E.5.

(i) All rider/endorsement forms must contain the name and address of the company, the signature of at least one officer of the company and written consent of the policyholder. Section 3220(a)(2).

(j) Variable material used with impairment, waiver or exclusion riders must be submitted with the form for approval. § I.E.2.

(k) There is no filing fee required in New York..

(l) If the filing is made on behalf of the company by another party, a letter of authorization from the company must be submitted by the party authorized to submit the filing.

(m) Filings that are incomplete or do not comply with applicable laws and regulations will be closed. Circular Letter 1997-14.

2. Special Rules for Combination Submissions

(a) Combination submissions are usually comprised of a group life insurance policy and certificate that provide one or more types of accident and health insurance benefits in addition to the principal life insurance benefit. Combination submissions may also include group or individual application forms and/or enrollment forms to apply for both life insurance and accident and health insurance coverage.

(i) To simplify and expedite the review process, the addition of the accident and health insurance benefits to the life insurance policy and certificates should be done using a separate rider or insert page form. The accident and health insurance rider or insert page form must have a unique form number to distinguish it from the underlying life insurance policy and certificate forms. The policy/certificate, riders and insert pages should be such that those pertaining to life insurance contain no accident and health provisions and the policy/certificate, riders and insert pages that pertain to accident and health insurance contain no life insurance provisions. Forms that do not comply with this filing procedure will not be accepted, except as provided in section (c) below.

(ii) The policy forms dealing with life insurance should be submitted to the Life Bureau only and the policy forms dealing with accident and health insurance should be submitted

to the Health Bureau only. The policy forms submitted to the Health Bureau must be accompanied by the requisite actuarial memorandum and rate manual pages.

(b) Whether accidental death benefits should be submitted to the Life Bureau or to the Health Bureau will depend on the specifics of the benefit(s) being provided.

(i) If the accidental death benefit is provided in conjunction with life insurance and does not include dismemberment, it is life insurance and should be submitted to the Life Bureau only. An additional benefit in the event of death by accident is defined as life insurance under §1113(a)(1) of the Insurance Law.

(ii) If the accidental death benefit is a stand alone benefit that can be purchased or maintained independently of life insurance coverage or if the benefit includes dismemberment, it is accident and health insurance and should be submitted to the Health Bureau only. Accident insurance benefits are recognized under Section 1113(a)(3) of the Insurance Law and Section 52.9 of Regulation No. 62 as a type of accident and health insurance.

(c) Application and/or enrollment forms that may be used to apply for both life insurance and accident and health insurance coverage must be submitted to both the Life Bureau and to the Health Bureau for review and approval. Also, any riders, endorsements or revised memoranda of variable material to be used with previously approved combination forms must be submitted to both Bureaus.

(i) The submission letter to each Bureau should clearly indicate that the form may be used with both life insurance and accident and health insurance. The submission letter should also state that an identical submission of the form has been made to both Bureaus.

(ii) Any correspondence from the company during the course of the submission and any revised forms must be provided to both Bureaus.

(iii) Each Bureau will send a separate approval letter to the company. The form may not be used until approval of the same version has been received from both Bureaus.

(iv) It is the responsibility of the company making the submission to make sure that the same version of the form is approved by both Bureaus. Since each Bureau offers a variety of expedited submission methods and maintains separate filing queues, it may not be possible for both Bureaus to review the submissions simultaneously. For example, if the company uses an expedited process with one of the Bureaus and obtains an approval before the other Bureau has had an opportunity to review the form and the second Bureau requests changes to the form; the revised version of the form will need to be resubmitted to the first Bureau for approval. The only version of the form that may be used is the version that has been approved by both Bureaus.

3. Response to Department Comment Letter

When responding to a comment letter, it is helpful to include a red-lined copy of the form(s) showing where changes have been made. If the company is making any changes to the forms other than requested in the Department's comment letter, such changes should be noted in the company's response letter. (However, "place holder" filings are not permitted. If the Company wished to substantially revise pending forms and their underlying product design, the pending filing should be withdrawn and a new form filing made to the Department.)

4. Explanation of Variable Material

(a) Illustrative material may be used for items which may vary from case to case such as names, dates, premiums and schedules for determining the amount of insurance for each person insured. § I.F.4. of Circular Letter 6 of 1963.

(b) Material in forms other than illustrative items may vary if the filing includes a Memorandum of Variable Material. Variable material must be clearly indicated in forms (e.g., with bracketing or underlining). How material is designated as variable should be stated in the submission letter and in the explanatory memorandum. The Memorandum of Variable Material must clearly indicate the nature and scope of the variations to be used for the variable portions of provisions such as insuring clauses, benefit provisions, restrictions, eligibility requirements, and termination of coverage provisions. § I.F.4.

(i) The Memorandum of Variable Material should be drafted in sufficient detail to determine the scope of variation for each variable item. Where text is variable, the memorandum should include alternative text and/or an explanation of when the bracketed text will be omitted from the form. Similarly, variable numerical items should include the range (i.e. minimum and maximum) of variation. It should be clear which item in the explanation corresponds to which variable item in the form. One option would be to number the items in the explanation of variable material and place the number of the item from the explanation next to the corresponding variable item in the form.

(ii) An explanation of variable material that the variations "will conform to law" or "as requested by the policyholder" is not acceptable.

(iii) The explanation of variable material and subsequent amendments to the explanation of variable material are subject to approval.

(iv) If a form is submitted with areas denoted as variable but without an explanation in a memorandum of variable material, only the information appearing in the form may be used, The use of any other variation would be considered use of an unapproved form.

(v) The memorandum of variable material must include a version/revision date.

(d) Open-face riders or endorsements may be submitted for approval for general use in amending variable material within the limitations of § I.F.4 of Circular Letter 6 of 1963. However, any text that will be used in the rider must be provided.

(i) See also section III.D.2.f below.

5. Submission Letters

Circular Letter 1963-4; Circular Letter 1963-6; Circular Letter 1969-4, Circular Letter 1999-8.

A submission letter must:

(a) Be provided in duplicate, signed by a representative of the company authorized to submit forms filing or approval. Circular Letter 1963-6 § I.G.

(b) Identify the Insurer.

(c) List the form numbers being submitted. Circular Letter 1963-6 § I.G.1. and Circular Letter 1999-8

(d) Include a Table of Contents of all material in the filing.

(e) When the policy form is designed as an insert page form, the insurer must submit a statement of the mandatory pages which must always be included in the policy form, and a list of all optional pages, if any, including application forms, together with an explanation of how the form will be used. Previously approved forms should be identified by form number and approval date. See § I.G.8. See also Circular Letter 1963-4 Guidelines for Examination of Group Life Forms § I.A.2. Copies of the previously approved base policy and certificate into which the insert pages will be incorporated must also be submitted for informational purposes if said policy or certificate was approved prior to 1998.

(f) Include a description of the benefits and coverage provided. Circular Letter 1963-6 § I.G.2 and 7. The submission letter should explain purpose and use of each form submitted if such purpose and use is not indicated on the policy form. Circular Letter 1963-6 § I.E.1.

(g) Identify the applicable paragraph(s) in §4216(b) which best describes the group or groups for which the policy forms are intended. The statement that the forms are for use with all eligible groups should be avoided.

(h) Identify the eligibility classes covered, as defined in Section 4216 (i.e., conditions pertaining to employment and family status) as well as the rate classes (e.g., age, gender, smoker status, family status). See Circular Letter 1963-4 Guidelines for Examination of Group Life Forms § I.B.2.

(i) Include a statement as to whether the policy is contributory or non-contributory. If the policy is contributory for some insureds, or for some levels of insurance, or under some conditions, indicate the situations or conditions under which contributions from the insureds would be permitted or required. (For example, a policy may provide non-contributory basic life and optional contributory supplemental life insurance).

(j) Include a statement as to whether the form is new or is intended to replace a previously approved form. Circular Letter 1963-6(I)(G)(3), (4), (5), (6), and (8).

(i) If the form is intended to supersede another approved or filed form, the number of the approved or filed form, together with a statement, of the material changes made; if the previous form is still in process, the form number, file number, and submission date. A redlined copy is helpful.

(ii) If a form being filed for formal approval had previously been submitted for preliminary review, a reference to the previous submission and a statement setting out either (1) that the formal filing agrees precisely with the previous submission or (2) the changes made in the form since the time of preliminary review. A redlined copy is helpful. Any resubmission of the forms must address all outstanding issues in the new submission letter. The new submission must be complete in and of itself and not incorporate previously submitted material by reference.

(iii) If the form is other than a policy or contract, give the form number of the policy or contract form or forms with which it will be used. A copy of the policy or contract forms with which the submitted form will be used must also be submitted for informational purposes if said policy or certificate was approved prior to 1998. If the form is for more general use describe the type or group of such forms.

(iv) If an insurer wishes to replace a very recently approved form because of an error found in the approved form and the form has not been issued, the insurer may either make an entirely new submission or may make a substitution request. To make a

substitution request, the insurer must return the original approval-stamped form with a statement in the accompanying letter that the form has not been issued. The insurer may, under these circumstances, use the same form number on the corrected form being submitted. Substitution is not available if the form has been issued or if approval was granted on a certified basis under Circular Letter 6 of 2004 whether or not the form was issued. For a new submission, the corrected form must have a new unique form number and the insurer need not return the previously approved form..

(k) Include a statement as to whether or not Compensation Schedules are included.

(l) Include a statement as to whether the group policy will be delivered or issued for delivery in New York or outside of New York. In addition, include a statement as to whether the certificate will be delivered or deemed delivered in New York or outside of New York.

(m) Identify and explain any unique or innovative product or product feature and identify any special market for the product. In general, an innovative or unique product/feature would include one that has not been previously approved by the Department for the insurer or is new to the marketplace in NY.

(n) Noncompliance Explanation: If the policy does not comply with a specific product outline provision, the submission letter must identify the provision and provide a complete explanation of the Company's position on the issue. Such submissions may not be submitted through the Circular Letter 6 (2004) certified process unless the Department has given permission.

(o) Advise whether the policy/certificate is sex-distinct or unisex. If sex-distinct, the letter must confirm that the certificate will not be delivered under the policy in any employer-employee situation subject to the Norris decision and/or Title VII of the Civil Rights Act of 1964.

(p) Include a caption as follows:

The "re" or caption of the submission letter must identify all forms submitted for approval or acceptance. Specify form number, designate form as individual or group, provide a generic product description and generic form description. Explanations of variable material must also be included in the list of forms, separately for each affected form. See Circular Letter No. 8 (1999).

Section 3201(b)(6) ("Deemer") filings must be so identified in the "re" or caption.

Circular Letter No. 6 (2004) filings must be so identified in bold print in the "re" or caption.

(q) Indicate whether the policy is in whole or in part on a plan of insurance other than the term plan as anticipated by Section 3220(a)(11). If the policy is in whole or in part on a plan of insurance other than the term plan, then the submission should either include an actuarial certification that no nonforfeiture values would be required if Section 4221 and Regulation 149 were applied or provide justification as to why the superintendent should find the nonforfeiture value or lack of them acceptable.

6. Readability Requirement -- Flesch Score Certification

Readability requirements described in Section 3102 apply to any policy covering a group with fewer than 100 lives, and to any certificate issued pursuant to a policy delivered or issued for delivery in New York, but do not apply to variable life products.

Provide Flesch score certification.

(a) The Flesch score must be at least 45.

(b) See February 18, 1982 letter from Department for sample certification form. Copies of this letter can be obtained from this Bureau.

7. Key Legal Sources

(a) Insurance Law Sections 3105, 3201 (Approval of Forms), 3203, 3204, 3205, 3208, 3214, 3220 (Standard Provisions), 3227, 4216, 4221 (Standard Non-Forfeiture General Account), 4228.

(b) Insurance Regulation 123, 143, 34-A.

(c) Circular Letters 12-21-1949, 1957-4, 9-8-1960, 7-19-62, CL4 (1963), CL6 (1963), CL1 (1964), CL4 (1969), CL3 (1977), CL16 (1993), CL2 (1994), CL3 (1996), CL14 (1997), CL2 (1998), CL8 (1999), CL6 (2004), CL14 (2006) and CL 27 (2008).

(d) Other: Article VII of the Abandoned Property Law, NY State Tech. Law §301-309.

III. Contract Provisions

A. Cover Page

1. Company Name and Address

(a) The licensed New York company's name appears on the cover page (front or back) of the group policy and the certificate.

(b) Full street address of the company's home office appears, for disclosure purposes, on front or back cover page of group policy and certificate.

(c) The name of the insurer must be prominently displayed on the cover page. If the name of another entity is included on the cover page (insurance group designation, name of the parent company or affiliate, name of the group policyholder, etc.) or if a logo, trademark or other device is included, such name or device shall not be displayed in a manner that would have the tendency to mislead or deceive as to the true identity of the insurer, or create the impression that someone other than the insurer would have any responsibility for the financial obligations under the policy/certificate. See Section 3201(c)(1) . Note that this requirement would also apply to all application/enrollment forms.

(d) No unlicensed insurer's name can appear anywhere on the form. Section 3201(c)(1).

2. Free Look Provision

(a) If a free look provision is provided by the company, it must be clearly explained on the cover page of the group policy and certificate forms.

(b) Note that §3220 of the Insurance Law does not require a free look provision. The certificate may include a free look provision complying with §3203(a)(11) for voluntary group term life insurance funded solely by employee or member contributions.

3. Form Identification Number

A form identification number must appear in the lower left-hand corner in accordance with Circular Letter 1963-6 § I.D.

4. Brief Description of Coverage

A description of the coverage (e.g., Annually Renewable Nonparticipating Contributory Group Term Life) must appear on the cover page of the group policy and certificate forms. Such description must indicate:

(a) Whether the coverage is contributory, non-contributory or both;

(b) Length of the term (e.g., yearly renewable, 20-year term);

(c) Type of policy (i.e., group term life);

(d) Whether the policy is renewable or non-renewable; and

(e) Whether the policy is participating or non-participating.

5. Officer's Signature(s)

The signature of at least one officer of the company must appear on the group policy forms to execute the contract is required as a matter of contract law. To avoid having to resubmit new forms to the department in the event of a change of officers, it is recommended that the officer's name and signature be designated as variable illustrative material.

6. Disclosure

The cover page must also set forth any disclosure required to be on the cover page. For example, section 3201(c)(4) provides that the superintendent shall not approve any life insurance policy form containing any war or travel exclusion or restriction, for delivery or issuance for delivery in this state, unless such policy form shall have printed or stamped across its face in red and in capital letters not smaller than 12-point type the following:

"READ YOUR POLICY (CERTIFICATE) CAREFULLY.

"CERTAIN (WAR, TRAVEL) RISKS ARE NOT ASSUMED.

_____

(State which or both)

IN CASE OF ANY DOUBT WRITE YOUR COMPANY (SOCIETY) FOR FURTHER EXPLANATION."

B. Statement of Protection

Every certificate must contain a statement of the insurance protection to which the certificate holder is entitled. Section 3220(a)(4). At a minimum, the certificate should include:

(1) The name of the certificate holder and/or class of certificate holders to which the coverage applies; and

(2) The dollar amount of the basic life insurance benefit (and supplemental life insurance benefit if supplemental life is elected) for that particular certificate holder or class of certificate

holders or a description of how the basic benefit will be determined (e.g. multiple of salary); and

(3) The cost to the certificate holder of the basic life and/or supplemental life insurance benefit if the plan is contributory (i.e. an explanation of how contribution amounts are calculated); and

(4) Whether dependent coverage is provided and in what amount; and

(5) Any optional benefits elected by the certificate holder; and

(6) An effective date of coverage including any waiting periods.

Permissible ways to include the above information in the certificate include, but are not limited to, attaching the enrollment form as part of the certificate or including a certificate specification page.

C. Table of Contents

A table of contents is required for policies that are more than 3,000 words or more than three (3) pages regardless of the number of words in accordance with Section 3102(c)(1)(G).

D. Standard Provisions

Group life policies must contain in substance the following provision or provisions which in the opinion of the superintendent are more favorable to certificate holders or not less favorable to certificate holders and more favorable to policyholders.

1. Incontestability

(a) Section 3220(a)(1) requires a provision stating the policy is incontestable after two years from its date of issue, except for non-payment of premiums by the policyholder.

(i) Pursuant to Section 3203(a)(3), the policy should be incontestable after being in force for two years *during the life of the insured* for a period of two years. We would not object to the italicized language.

(ii) Incontestability cuts off a claim of fraud in the application. Accordingly, we object to any qualification of the incontestability provision with language such as, "in the absence of fraud".

(b) If the benefit provided is related to life insurance or provided in conjunction with life insurance (e.g., acceleration of the benefit, continuation, portability, etc.), the incontestability provision from §3220(a)(1) applies to that benefit.

(c) Section 3203(a)(3) adds that if a policy provides that the death benefit provided by the policy may be increased, or other policy provisions changed, upon application of the policyholder (certificate holder) and the production of evidence of insurability, the policy with respect to each such change shall be incontestable after two years from the effective date of such increase or change, except in each case for nonpayment of premium.

For group life insurance, if there will be a renewed contestability period for applied for increases, the policy and certificate must clearly state that such contestability period will be applicable only to "applied for" increases and will be applicable only to the amount of the applied for increase. The contestability period for applied for increases may not extend beyond 2 years from the effective date of the applied for increase.

(d) Section 3220(a)(1) also provides that no statement made by any person insured under the policy relating to his or her insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime and in

no event unless a written instrument signed by him, a copy of which is or has been furnished to such person or to his or her beneficiary.

(e) Any policy or certificate issued as a result of a conversion (or portability) option must indicate that the incontestable period for the converted (or ported) amount does not start anew, but is effective as of the date the original group policy coverage was issued. See Circular Letter 1963-4 § II.H.6.

(f) Must be based on "material misrepresentations" in accordance with Section 3105.

(g) The incontestability provision should not refer to "voiding" or "canceling" coverage. The company may contest coverage during the 2-year contestability period. It is for a court of law to determine whether an agreement is "void".

(h) The policy and certificate may not include language to the effect that disputes will be resolved in the sole discretion of the insurer.

2. Entire Contract**.**

Sections 3220(a)(2) and 3204, and Circular Letter 1963-4

(a) Section 3220(a)(2) requires a provision stating: "The rights of any policyholder, insured or beneficiary shall not be affected by any provision not contained: (a) in the policy, riders, endorsements, or amendments signed by the policyholder and the insurer, (b) in the policyholder's application attached to the policy, or (c) in any individual statement submitted with the application.

(b) Section 3204(a)(1) requires that the approved policy forms contain the entire contract between the parties. Section 3204(a) further provides:

(i) Nothing shall be incorporated therein by reference to any writing, unless a copy thereof is endorsed upon or attached to the policy when issued.

(ii) No application shall be admissible in evidence unless a true copy was attached to the policy when issued.

(iii) Such policy cannot be modified, nor can any rights or requirements be waived, except in writing by a person specified by the insurer in such policy.

(iv) All statements made by, or by the authority of, the applicant for the issuance, reinstatement, or renewal of such policy shall be deemed to be representations and not warranties. See also Section 3105.

(v) No insertion or other alteration of any written application shall be made by any person other than the applicant without his/her written consent, except that the insertions may be made by the insurer for administrative purposes only in such manner as to indicate that the insertions are not be ascribed to the applicant.

(vi) Note: a table or schedule of rates, premiums or other payments which is on file with the Superintendent for use in connection with such policy or contract is excepted from the requirements of Section 3204(a).

(c) The Guidelines for Examination of Group Life Forms in Circular Letter 1963-4 §I.B.12 provides that incorporation by reference is governed by Section 3204(a). References to other sources to determine factual situations, such as facts of employee status, membership in a collective bargaining unit or a union, other benefits, salary, termination of employment or membership, etc., are not incorporations by reference.

(d) The entire contract provision shall not include the words "in absence of fraud." Circular Letter 1963-4, §II.H.7.

(e) The entire contract provision in the policy/certificate should include reference to the certificate. The policy/certificate shall not include language stating that the certificate merely summarizes the terms of the group policy. The policy/certificate shall not state that the terms of the group policy control in the event of a conflict between the policy and the certificate, especially where coverage is voluntary and the certificate holder pays part or all of the premium. To the extent that the terms conflict, the forms can be viewed to be misleading in violation of Section 3201(c)(1).

(f) Changes to the Entire Contract (Riders/Endorsements)

(i) Riders and Endorsements are policy forms and must be submitted to the Department for approval in accordance with section 3201.

(ii) All riders and endorsements must contain the name of the insurer, the signature of an officer of the insurer, and the effective date of the rider. See Circular Letter 1963-4 Guidelines for Examination of Group Life Forms § III.1

(iii) Any policy rider or endorsement that affects the rights and benefits of the certificate holder, whether positively or negatively, must have a corresponding certificate rider or endorsement which will be delivered to the certificate holder.

(iv) Except for riders and endorsements by which the insurer exercises a specifically reserved right under the policy or which concern only administrative changes, all riders and endorsements which may be added to the master policy after date of issue and which diminish rights, benefits and/or coverage in the policy should provide for signed acceptance by the policyholder .If the certificate holder pays a part or all of the premium and the group policy was issued outside of New York to a group not recognized under section 4216(b), written certificate holder consent must be obtained for changes that reduce or eliminate rights or benefits of the certificate holder. Section 59.4(b) of Regulation 123. Also, if the group is a discretionary group approved pursuant to section 4216(b)(14) the superintendent may require such certificate holder consent as a condition of approving the discretionary group. If the certificate holder pays a part or all of the premium and the group is other than as described above, certificate holder consent must be obtained unless the certificate and enrollment forms contain prominent disclosure indicating that: a) the policy permits the group policyholder to change, reduce, restrict or terminate the certificate holder's rights or benefits under the policy without the certificate holder's consent and b) such change, reduction, restriction or termination may occur at a time when the certificate holder's health status has changed and may affect his or her ability to procure individual coverage. Section 3201(c).

3. <u>Misstatements</u>

(a) Section 3220(a)(3) requires a provision for the equitable adjustment of the premium, or if the amount of insurance depends on the age of the insured, for the equitable adjustment of the amount of insurance and the premium in the event of a misstatement of the age of the person insured.

(b) If the premiums, benefits, or values differ depending upon the sex of the insured, the misstatement of age provision may include an adjustment in the event of misstatement of sex. See Circular Letter 1963-4 § II.H.8. Note that products sold in the employer/employee market are generally subject to the Arizona v. Norris decision and must use unisex rates.

(c) The provision may provide for equitable adjustment of the premium or amount of insurance based on misstatement of facts in addition to age or sex, if premiums, benefits,

or values differ depending upon those other factors, but adjustment based on those other factors is limited to the first two years that coverage is in force. Section 3220(a)(1).

4. Certificate Issuance and Validity

(a) Section 3220(a)(4) requires a provision stating that the insurer will issue a certificate to the policyholder for delivery to the person whose life is insured under such policy containing a statement of the insurance protection to which s/he is entitled including any changes in such protection depending on the age of the person whose life is insured and the statutory conversion rights.

Section §4216(b)(1), (2), (6), (7), (10), (11), (12), (13) requires issuance of a certificate to the policyholder for delivery to the person insured or such beneficiary as evidence of insurance.

(b) The certificate must include in substance all provisions of the policy that are directly relevant to the insureds, including provision related to premium contributions (e.g. provisions related to the circumstances in which certificate holders are required to contribute if coverage is contributory, provisions related to the circumstances in which certificate holders must pay premium directly to the insurer, etc.).

(i) Any inconsistencies or conflicts between the group policy and certificate must be eliminated prior to approval. The terms of the group policy must not conflict with the terms of the certificate. Otherwise, the certificates would be misleading.

(ii) The policy and certificate must include a statement that nothing in the group policy invalidates or impairs any rights or benefits as stated in the certificate or granted by New York law. Note that certificates deemed to be delivered in New York under a group policy issued out-of-state to a non-recognized group are subject to individual or group standards that afford the insured the greatest protection, as determined by the Superintendent, pursuant to § 59.4(b) of Regulation No. 123.

(iii) Certificate forms delivered or deemed to be delivered in New York must clearly state that rights and benefits granted to the certificate holder will not be less than those required by New York law.

(iv) Certificates may be issued to the policyholder electronically for delivery to the certificate holder. Circular Letter 33 of 1999 and Supp. No. 1 to Circular Letter 33 (09/03/2002). Electronic issuance to the policyholder may only be used where the policyholder has agreed, in advance, to electronic issuance. If the insurer delivers the certificate directly to the certificate holder, electronic delivery of the certificate may be used only if the certificate holder has agreed, in advance, to electronic delivery. NY State Tech Law §309. Posting certificates on the insurer's website may satisfy the issuance or delivery requirements as long as consent, as noted above, has been obtained. While the insurer's procedures for electronic delivery need not be set forth in the policy or certificate, the procedures should result in actual receipt of the correct certificate(s), should protect the confidentiality of certificate holder information and, where applicable, comply with NY State Tech. Law §301-309.

5. Beneficiary, Facility of Payment, and Payment of Benefits

(a) Designated Beneficiary. Section 3220(a)(5) of the Insurance Law requires a provision stating that the benefits payable under the policy shall be payable to the beneficiary or beneficiaries designated by the insured.

(b) Specified Beneficiary. If policy contains conditions pertaining to family status, the beneficiary may be the family member specified in the policy. (See L.1959, c 464 "family status" amendment). Employers wanted to make sure that spouse and/or children would receive death benefit for life insurance amounts typically paid for by the employer.

(c) Absence of Designated or Specified Beneficiary. If no designated or specified beneficiary survives the insured, the insurer has the option to pay the amount of insurance to the estate of the insured or to surviving relatives in accordance with a specified order of taking set forth in the policy/certificate. The surviving relatives in the order of taking may include the following: spouse/domestic partner, parents, children or siblings.

(d) Insurer may deduct from the death benefit an amount not to exceed $500 to be paid to any person or persons appearing to the insurer to be equitably entitled to such payment by reason of having incurred expenses on behalf of the insured or for his or her burial. Section 3220(a)(5).

(e) The policy and certificate should clearly describe how primary and secondary beneficiary designations operate if being made available, and should describe how multiple beneficiary designations are handled.

(f) Any change in the beneficiary designation should take effect on the date the notice of change is signed, subject to action taken (i.e. payment of claim) by the insurer prior to receipt of this notice. The effective date of the change should not be delayed until the change has been processed by the insurer. The policy/certificate should not include language delaying the effective date of the change until the insurer has "recorded", "accepted" or "acknowledged" the change.

(g) Pursuant to Section 4216(b), the policy/certificate shall provide for payment of all benefits thereunder, to the person insured or to some beneficiary or beneficiaries other than the policyholder except as provided in

(i) Section 4231(b). See Dividend and Rate Credits section of this outline.

(ii) Section 3220(a)(5) (Payment to specified family members)

(iii) Section 4216(i)(2) and Section 3205(d) (COLI).

(h) If irrevocable beneficiaries are permitted, the beneficiary provision must clearly explain that such beneficiaries cannot be changed without the written consent of the irrevocable beneficiaries.

(i) Policy language may not refer to the placement of death proceeds into a checking or other type of account since this would relate only to the manner of distribution. Section 3201(a).

Settlement options need not appear in the policy/certificate. However, in light of Circular Letter 4 of 2012, in order for insurers to be able to offer settlement options, in addition to the payment of the full life insurance proceeds in a single check to the beneficiary, language needs to be included in the policy form that indicates that additional options may be made available. The Department would consider the following language acceptable and would consider alternatives on a case-by-case basis:

"Unless otherwise elected by the certificate holder or beneficiary, benefits will be paid in a single lump sum check. We may make other options available in addition to the single check option."

or

"When the benefit is payable, we will pay it in a single lump sum check, unless another method of payment is requested by the certificate holder or beneficiary and agreed to by us."

(j) The policy/certificate may not include reserved rights for the insurer to withhold payment of the death benefit from the beneficiary or to pay the benefit to other than the beneficiary upon the insurer's own determination that the beneficiary is physically or mentally incompetent to receive payment as this would appear to be inconsistent with Article 81 of the NY Mental Hygiene Law and the Americans with Disabilities Act.

(k) The policy/certificate must set forth the specifics of what is necessary to process the claim (e.g., written request, copy of death certificate). The insurer may include a provision in the policy/certificate that an autopsy may be requested "where not prohibited by law".

(l) If there is contract language regarding interest on the deferral of death proceeds, such language may not be inconsistent with Section 3214.

6. Renewal Premium Notice

(a) Section 3220(a)(10) of the Insurance Law provides that group life policies covering members of a labor union or other association must include a notice to the effect that the premium for renewable term depends on attained ages of the members of the group, and increases with advancing ages.

(b) This notice does not apply to group life policies issued to groups described in §4216(b)(1) or (3) (i.e. covering employees of a single employer or debtors of a creditor or buyers from a vendor).

7. Assignment

(a) Unless the policy expressly prohibits or restricts the right of assignment, an insured is permitted to make an assignment of all or any part of his/her incidents of ownership in such insurance, including any right to designate beneficiaries and any right to convert to an individual policy. Section 3220(c).

(b) If the policy permits assignment of the insured person's rights for any purpose, it may not restrict assignment for purposes of viatical or life settlements. Section 3220 (c)(3).

(c) Insurer's procedures on assignments should be described in the policy and certificate. Assignments must be effective on the date the assignment is signed, subject to action taken (e.g., payment of claim) by the insurer prior to receipt of notice of assignment. The effective date of the assignment should not be delayed until the change has been processed by the insurer. The policy/certificate should not include language delaying the effective date of the assignment unit the insurer has "recorded", "accepted" or "acknowledged" the assignment.

(d) The policy and certificate must comply with Section 3212.

8. Termination, Discontinuation and Replacement

(a) The policy and certificate shall state specifically and clearly all events that would cause termination of the policy, as well as all events that would cause termination or reduction of an insured employee or member's coverage. Similarly, the policy and certificate shall specifically identify any party that has the ability to terminate the policy (e.g. policyholder, insurer) or terminate or reduce the insured's coverage (e.g. policyholder, member/employee, participating employer in the multiple employer trust context). See Circular Letter 1963-4 Guidelines for Examination of Group Life Forms §I.B.4.

(b) Discontinuance

(i) A notice of discontinuance given by the insurer shall include a request to the group policyholder to notify certificate holders covered under the policy of the date as of which the group policy, contract or certificate will discontinue and to advise that, unless otherwise provided in the policy, contract or certificate the insurer shall not be liable for claims for losses incurred after the date of discontinuance and the subsequent conversion application period. The notice of discontinuance also shall advise, in any instance in which the plan involves certificate holder contributions, that if the policyholder continues to collect contributions for the coverage beyond the date of discontinuance, the policyholder may be held solely liable for the benefits with respect to which the contributions have been collected. The notice shall indicate that such discontinuation of the group policy shall not result in discontinuation of coverage where disability benefit or waiver of premium for unemployment benefit, including any waiting period therefore, is in effect.

(ii) The insurer shall prepare and furnish to the policyholder at the same time it gives a notice of discontinuance a supply of notice forms to be distributed to the certificate holders concerned, indicating the discontinuance and the effective date of the discontinuance, and urging the certificate holders to refer to their certificates in order to determine what rights, if any, are available to them upon the discontinuance.

(iii) This section is in addition to and not in substitution of the insurer's and/or the policyholder's obligations under the conversion provisions outlined in Section 3220(a) of the Insurance Law and this outline.

(c) Replacement

(i) The policy/certificate may not exclude or restrict coverage for a loss incurred while the policy/certificate is in-force merely because the claim for such loss is made after the replacement. The claim should not be lost as a result of the replacement. There may be instances where the original insurer and replacing insurer have entered into an agreement whereby the replacing insurer assumes liability for those claims arising under the original policy. In that event, the replacement policy/certificate should reflect such an arrangement.

(ii) The Department offers the following "best practice" suggestions for replacements. Please note that theses are not required policy form provisions. If possible, no group policy should be written replacing a plan of similar benefits of another or the same insurer unless all persons of the same class insured under the prior policy/certificate are eligible, without evidence of insurability, under the new policy/certificate. Also, if possible there should be no gap in coverage between the prior and replacement policy/certificate.

9. Right to Audit

The policy shall contain a reserved right for the insurer to audit the policyholder's records as needed to administer the policy. The group certificate need not include this provision.

E. Conversion Privilege and Notice of Conversion

1. Conversion Right

(a) Pursuant to Section 3220(a)(6) of the Insurance Law, an employee or member shall be entitled to have issued to him or her by the insurer a policy of life insurance upon the termination or reduction in coverage only under the following conditions:

(i) without evidence of insurability,

(ii) upon application made to the insurer within 31 days after such termination or reduction of insurance or within any extended conversion notice period, whichever is later. See "Notice of Conversion" below.

(iii) upon payment of premium applicable to:

(I) the class of risk to which he/she belongs under the group policy (i.e. if the insured belongs to a class under the group policy that is charged unisex rates [e.g., a policy issued to an employer subject to Title VII of the Civil Rights Act of 1964] he or she may not be charged sex-distinct rates under the individual conversion policy. Similarly, if the insured belongs to a class under the group policy that is charged unismoker rates, he or she may not be charged smoker (or tobacco) distinct rates under the individual conversion policy.), and

(II) the form and amount of the policy at his/her then attained age;

(iv) the policy of life insurance is in any one of the forms customarily issued by such insurer, except term insurance. Note that "any" is interpreted to mean a choice by the insured from all forms customarily issued by the insurer.

(b) We have permitted affiliated and unaffiliated insurers to provide the individual conversion benefit where the group life insurer does not offer any individual policies under limited circumstances. We review the contractual arrangement between the two insurers, the subsidy or charge made against the group life insurer and the rate class to which the convertees convert. Where the arrangement occurs between affiliates, the transaction is also subject to approval of the Department's NYC office (see Insurance Law Article 15). The Department would expect the contractual arrangement to provide for a permanent plan (e.g., Whole Life) and a meaningful term policy.

(c) Conversion rights under Section 3220(a)(6) do not apply to groups described in Section 4216(b)(3) (credit life) or (8) (municipal corporation or public housing authority).

(d) The effective date of the individual conversion policy shall be the date of termination of coverage under the group policy.

2. Triggering Events

Termination or Reduction in Coverage and the Amount that can be Converted.

(a) Employee's or member's group life insurance coverage ceases because of termination of:

(i) employment or membership in the class or classes eligible for coverage. Note that retired employees must be granted equitable rights of conversion for individual termination of coverage. See Circular Letter 1963-4 Guidelines for Examination of Group Life Forms § I.B.6. and Circular Letter dated June 2, 1953.

(ii) the policy - (See replacement or reinstatement of such group policy).

(iii) for an insured covered under a Section 4216(b)(12), (13) or (14) group policy, within 31 days after notice from the insurer that to continue coverage, he/she must contribute more than 133% of the net premiums computed according to the Commissioners 1960 Standard Group Mortality Table at 3.0% interest.

(iv) The insured may convert the amount of life insurance protection (including supplemental life coverage) in effect under the group policy at the time of such termination less any amount of life insurance remaining in force. See § 3 Replacement Coverage below for exception.

(b) Employee's or member's group life insurance coverage is reduced

(i) in the case of a policy covering an employee or union member under a plan arranged by the insured person's employer or union, on or after the employee's or union member's attainment of age sixty (60) in any increment or series of increments aggregating 20% or more of the amount of coverage in force before the first reduction on account of such age;

(ii) in the case of a policy covering any member other than described in item (i) above, at the time of the first reduction of insurance;

(iii) due to change in class; or

(iv) due to an amendment of the policy to take effect immediately or at any subsequent date.

(v) The amount of coverage that can be converted upon reduction of coverage depends on the type of group. For groups described in item (i) above, the insured may convert the amount of the aggregate reduction. For groups other than described in item (i) above, the insured may convert 80% of the amount of coverage in effect immediately prior to the reduction. The Department has approved provisions which provide that upon any reduction, the insured has the right to convert the amount of the reduction.

3. Replacement Coverage

The group policy may (i.e. permissive) contain a provision that if the policyholder or insurer terminate the policy, the amount of life insurance that may be converted shall in no event exceed the amount of such employee's or member's life insurance protection less any amount of life insurance for which he/she may be or may become eligible under any group policy issued or reinstated by the same or another insurer within 45 days after the date of such cessation.

4. Preliminary Term Insurance Section 3220(a)(6)

At the option of the employee or member, he/she shall be entitled to have issued to him/her a policy of life insurance only, in any one of such forms:

(a) preceded by term insurance for a period of one year,

(b) with the premium payable, at the option of the employee or member, in any mode customarily offered by the insurer.

5. Total and Permanent Disability Benefit - (L.1997,c.287).

(a) This benefit is a mandated additional benefit.

(b) If an employee's or member's coverage ceases because of termination of employment or membership due to total and permanent disability, the employee or member shall be entitled to have issued to him/her:

(i) a policy of life insurance only, in any one of such forms (i.e. including term).

(ii) preceded by term insurance for a period of one year.

(iii) with premium payable at option of the employee or member, in any mode customarily offered by the insurer.

(iv) in an amount of such employee's or member's life insurance protection in effect immediately before termination, less the amount of any life insurance which is

replaced with the same or another insurer within 45 days after cessation of the group life insurance protection.

(c) We have interpreted the phrase "any one of such forms" to mean choice by the insured of any one from all such forms customarily issued by such insurer, including term insurance. Therefore, in addition to the one year preliminary term policy, any individual term life policies customarily offered by the insurer must also be made available for disabled convertees.

(i) Term insurance was not excepted from this benefit as is the case with the general conversion right.

(ii) Also, this additional benefit would have no meaning if term insurance was not available.

(iii) The term insurance alternative is consistent with the Legislature's goal of making conversion more affordable for insureds who are least able to afford more expensive options.

(d) For definitions of total and permanent disability, we have relied upon Section 3215, notwithstanding Section 3215(g). We will consider more favorable definitions.

6. Death During the Conversion Period

(a) A death benefit (equal to the full amount of death benefit payable under the original group policy) must be paid if death occurs within the 31-day conversion application period or any extended notice period pursuant to Section 3220(a)(8).

(i) Death of the insured before expiration of the 90th day of the notice period is deemed exercise of right of conversion if no notice is provided. Oakley v. National Western Life Ins. Co., D.C. N.Y. 1968, 294 F. Supp. 504; Payne v. Equitable Life Assur., 14 A.D.2d 266 (1st Dept. 1961).

(ii) The death benefit shall be payable under the original group policy if application for conversion has not been made at the time of death. The death benefit shall be payable under the individual conversion policy if satisfactory application for conversion has been made at the time of death. In the latter case, the insurer may deduct from the death benefit premiums owed under the individual policy.

(b) The policy may contain a provision obligating the policyholder to pay a premium to the insurer for this coverage extension if the extension is a direct result of the policyholder's voluntary termination of the policy and the policyholder replaces the coverage within six months with the same or another insurer.

7. Individual Conversion Policy

(a) Incontestability. The conversion policy may provide that statements made by the insured under the group policy relating to insurability under the group policy may be used in contesting the validity of the individual conversion policy only to the extent that such statement could have been used in contesting the validity of the coverage under the group policy if the group coverage had not ceased. The contestability period does not start anew for the conversion policy.

(b) Suicide. The individual conversion policy shall not exclude or restrict liability in the event of suicide of the insured after two years from the date that the insured became covered under the group policy.

8. Conversion for Dependents

(a) Pursuant to Section 3220(a)(7) of the Insurance Law, an employee/member has the option of covering dependents who were insured under the group policy under a converted policy upon termination or reduction of coverage as described in Section 3220(a)(6). The effective date of the converted policy or policies shall be the date of termination or reduction of the dependent's insurance under the group policy.

(b) The conversion privilege is also available

(i) to the surviving spouse, children or other dependents upon death of the employee or member insured under the group policy;

(ii) to a child of the insured or other child dependent upon attaining the limiting age of coverage under the group policy while insured as a dependent;

(iii) to the spouse or former spouse of the employee or member upon divorce or annulment of marriage of employee or to the domestic partner or former domestic partner of the employee or member upon termination of the domestic partnership.

(iv) to other dependents who no longer qualify as an other dependents under section 4216(f).

9. Notice of Conversion

Sections 3220(a)(8) and 4216(d) provide that notice to certificate holders is required in all cases when statutory conversion right is triggered, regardless of whether continuation or porting of coverage is also available. Notice shall be provided within the following periods:

(a) 31-Day Application Period – The certificate holder (and any person to whom conversion is available pursuant to Section 3220(a)(7)) must be notified of the conversion privilege and its duration within 15 days before or after the happening of the event. In the case of the death (or divorce) of the insured employee, the notice must be provided as required in Section 3220(a)(8) so that the dependent spouse can elect such conversion benefit.

(b) 45-Day Period After Notice - If notice of conversion privilege is more than 15 days, but less than 90 days after the triggering of such event, the time allowed for the exercise of the conversion application privilege should be extended for 45 days after the giving of such notice.

(c) 90-Day Period - If no notice is provided within 90 days after the triggering of the event, the time allowed for the exercise of the conversion application privilege expires at the end of 90 days.

(d) Full Compliance with Notice requirements by

(i) written notice by policyholder or insurer

(III) given to the certificate holder or

(IV) mailed to the certificate holder at the last known address; or

(ii) written notice by insurer mailed to the certificate holder at last address furnished to the insurer by the policyholder.

(e) For notice of Continuation and Portability requirements, see §10 (f) below.

(f) The notice to the certificate holder of the right to convert should be provided in such a manner to ensure that the dependent spouse, children or other dependents can exercise

their own independent right to convert as provided in Section 3220(a)(7). A separate notice would ensure that the required conversion right is available.

(i) Upon the death of the employee or member to the surviving spouse or other adult dependent with respect to such spouse or other adult dependent and children of the insured or other dependent children as are then insured by the group policy,

(ii) To a child of the insured or other child dependent upon attaining the limiting age of coverage,

(iii) Upon the divorce or annulment of the marriage of the employee or member or upon termination of a domestic partnership of the employee or member to the spouse, former spouse or former domestic partner of such employee or member.

(g) Written notice can be provided by the insurer or policyholder pursuant to Section 3220(a)(8). The group policy must indicate whether the notice will be provided by the policyholder or the insurer. The certificate need not include this provision.

10. Group Life Continuation and Portability -- Circular Letter No. 3 (1996)

"Continuation" refers to continuing to provide group coverage under the same group policy. "Portability" refers to providing group coverage through a different group policy typically issued to a portability trust.

Continuation and Portability are permitted as options in addition to the statutorily required conversion right on the basis of being more favorable to the certificate holder or not less favorable to the certificate holder and more favorable to the policyholder. Circular Letter 1996-3. We approve these benefits as more favorable based on the following being satisfied.

(a) Continuation and Portability options may be offered in addition to the conversion option (not as a substitute for conversion) when one or more of the events trigger statutory conversion rights. It is permissible to restrict the availability of the continuation or portability to only some of the instances where conversions are required to be available.

(b) Portability may be provided through a group life portability trust established solely for the purpose of making term life insurance available to employees or members whose coverage would terminate under the group life policy.

(i) This trust will qualify as a discretionary group under Section 4216(b)(14). Accordingly, the group will be subject to the requirements of Regulation 123, including the benefit ratio requirements.

(ii) Incontestability and suicide periods would relate back to the initial group life coverage.

(iii) As this group comes under §4216(b)(14), if rates exceed 133% of the corresponding net premium computed according to the 60 CSG Table at 3% interest, we will require the conversion option be available. Section 3220(a)(6).

(iv) Any provision restricting the portability option to healthy lives is not permitted. We will permit a restriction on insureds that are on a waiver of premium benefit.

(v) The submission of the forms that provide the portable coverage should include the memorandum required by Section 54.7 of Regulation 123.

(c) The insurance may be continued under the existing group life insurance policy.

(i) The contract must indicate whether premiums must be paid during the continuation period and who (e.g., employer, employee) must pay those premiums.

(ii) The contract and certificate must indicate that an insured with continued coverage has the ability to elect the statutory conversion right at any time the coverage is continued.

(d) The submission letter should include an explanation of how the rates for the continued lives are calculated. The calculation should be done in such a way that the rates are sustainable. By this we mean that in the absence of other considerations that as long as the actual experience follows expectations no rate schedule increases are necessary.

(e) The company should confirm in the submission letter that the rates for the various options (i.e. Conversion, Continuation, Portability) will be provided to the insured upon request. Such information is necessary for the consumer to make an informed decision as to which benefit to elect.

(f) Notice periods taken from section 3220(a)(6) and (8) – notice for availability of continuation and portability options is to be provided in the same manner with the same notice periods as required for conversion when the conversion right is triggered, and conversion notice must again be provided upon termination of continued or ported group coverage.

F. Other Provisions

1. Dividends

(a) In the case of a participating group life insurance policy, the dividend so apportioned shall, at the option of the policyholder be either payable in cash or be applied to the payment of premiums upon said policy. Section 4231(b)(7).

(b) If the policy is participating but dividends are not expected to be paid, the policy must so state.

(c) Any additional supplemental benefits attached to a participating policy, whether or not considered in determining surplus earnings, "may not" be specially labeled or described as nonparticipating. Circular Letter 1963-4 § II.F.3.

2. Experience Rating and Experience Rate Credits

(a) Pursuant to Section 4216(c)(2) of the Insurance Law, any group life policy may provide for readjustment of the rate of premium based on experience thereunder, at the end of the first policy year or of any subsequent year. Any such readjustment may be made retroactive only for such policy year. In addition, any such readjustment shall be computed on a basis which is equitable to all group insurance policies.

(i) For multiple employer trust groups, we generally do not permit the use of experience rating of individual employers participating in the multiple employer trust.

(ii) Circular Letter No. 3 (1977) states that the term "group dividend" refers to the payment of a refund of part of a redundant premium under a participating group life insurance policy and the term "group retrospective rate credit" is the similar payment under a nonparticipating group insurance policy.

(I) The amount returned or credited is based upon the actual experience of a particular group policyholder or of a class of group policyholders, or a combination of such experience.

(II) Such credits or refunds, like dividends, must be based upon an objective formula which is set forth explicitly in writing, is actuarially sound and which must be uniformly applied.

(III) A group retrospective rate credit must be approved by a board of directors in the same manner that a group dividend formula is required to be approved.

(b) Cost Plus No Claim Reserve Group Life not permitted. See Circular Letter dated September 8, 1960.

(c) Retrospective Rating. See Circular Letter dated December 21, 1949. Note that the prohibition in the December 21, 1949 Circular Letter in using retrospective rating in the first year is no longer enforced.

3. Use of Dividend and Retrospective Rate Credits

(a) Any dividend apportioned in a participating group life policy or any rate reduction on any nonparticipating group policy issued to an employer may be applied to reduce the employer's part of the cost of such policy, except that the excess, if any, of the employee's aggregate contributions under the policy over the net cost of insurance shall be applied by the employer for the sole benefit of employees. Section 4231(b)(7).

(b) Any Section 4216(b)(7) group (state troopers, policemen's benevolent association, uniformed firemen or volunteer firefighter or volunteer ambulance worker association) currently holding premium dividends shall be permitted to maintain said dividends for the general purposes of the entire membership. Section 4216(b)(7)

(c) For Section 4216(b)(10) groups (profession, trade or occupation association), if a policy dividend is declared or a reduction in rate is made, the excess, if any, of the aggregate dividends or rate reductions under the policy over the aggregate expenditure for insurance under such policy made from association or employer funds, including expenditures made in connection with the administration of such policy, shall be applied by the policyholder for the sole benefit of the insured individuals. Section 4216(b)(10)

(d) Section 4216(b)(12), (13) or (14) groups and New York residents insured under group policies delivered outside of New York to groups that are not described in Section 4216(b)(1)-(11).

(i) Any dividend apportioned on a participating group policy or any rate reduction on any non-participating group policy may be applied to reduce the policyholder's part of the cost of such policy, except that the excess, if any, of the insured's aggregate contribution under the policy over the net cost (gross premium less dividends or rate reductions) of insurance shall be applied at the discretion of the insurer either

(I) as a cash payment to the insured, or

(II) to reduce the insured's premium, unless the insured assigns the dividend or rate reduction to the policyholder

(ii) Upon policy termination, the insurer shall either make payment

(I) to the insured, or

(II) to the policyholder upon receipt of certification from the policyholder that the dividend or rate reduction will be distributed by the policyholder to the insureds or applied to reduce the insured's premium.

4. Claim Stabilization Reserves

If under the terms of the policy a claim stabilization reserve is maintained, the policy should state what happens to the reserve when the policy terminates.

5. Dependent Coverage - Section 4216(f)

(a) Spouse Coverage - A group life policy may provide for payment of a life insurance benefit upon the death of the spouse of the insured employee or member, provided that

insurance upon the life of the spouse shall not exceed the amount of insurance for which such employee or member is eligible at the time application is made for spouse coverage.

Insurers must recognize all legally married spouses including same-sex spouses married in New York and same-sex spouses whose marriage was legally performed outside of New York. The Marriage Equality Act of 2011 (Chapters 95 and 96 of the Laws of 2011) amended the Domestic Relations Law to authorize marriage of same-sex couples and to require that a same-sex marriage be treated the same as an opposite-sex marriage in all respects under New York law. See also Insurance Law §2607, Executive Law §296, Circular Letter 27 (2008) and Martinez v. Monroe Community College, 50 A.D.3d 189, 850N.Y.S.2d 740 (4th Dep't).

(b) Child Coverage - A group life policy may provide for payment of a life insurance benefit upon the death of the insured employee's or member's child dependent upon him or her for support and maintenance, provided the insurance upon the life of each dependent child shall not exceed the lesser of the amount of insurance for which the insured is eligible or $25,000.

(i) Natural children can be covered as dependents.

(ii) Adopted children can be covered:

A child may 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.

(c) Other Dependent Coverage – A group life policy may provide for payment of a life insurance benefit upon the death of persons other than the insured's spouse or child where that other person is "dependent upon the insured employee or member" in accordance with §4216(f). We have interpreted this to mean dependent upon the insured employee or member for support and maintenance. Generally, if a dependent meets the definition of dependent for purposes of §4235(f) they will also meet the definition of dependent for purposes of §4216(f), except where law or public policy requires a different result. For example, see (iii) below.

(i) Unilateral economic dependency or mutual economic interdependency is required to insure an Other Dependent.

The Policy/Certificate must set forth the complete terms and conditions of eligibility for Other Dependents. Please note that while the insurer may delegate to the policyholder the responsibility of determining which dependents are eligible for coverage, the policyholder should make that determination based on eligibility criteria established by the insurer and set forth in the Policy/Certificate.

(ii) Domestic Partners can be covered as Other Dependents.

While Domestic Partner coverage may be offered just to same-sex domestic partners or to both same-sex and opposite-sex domestic partners, it may not be offered just to opposite-sex domestic partners.

The Marriage Equality Act of 2011 has not disturbed the ability to also offer domestic partner coverage pursuant to §4216(f).

Note that if Domestic Partner coverage is terminated, conversion rights under §3220(a)(6) & (a)(7) must be provided.

(iii) Foster children can not be covered due to public policy concerns for the safety of foster children.

(iv) Stepchildren and children of the insured's domestic partner can be covered. If coverage is offered for stepchildren and domestic partner coverage is offered, then coverage must also be offered for the domestic partner's children. Section 2607.

(iv) The amount of insurance upon the life of an adult Other Dependent may not exceed the amount of insurance for which the insured is eligible. The amount of insurance upon the life of a child Other Dependent may not exceed the lesser of the amount of insurance for which the insured is eligible or $25,000.

(d) Avoidance of Substantial Adverse Selection -

(i) Section 4216(f) provides that insurers shall require evidence of insurability sufficient to protect against substantial adverse selection. For spouse coverage, the insurer should identify any guaranteed issue amount and describe how compliance with the requirement will be made.

(ii) The adverse selection risks inherent in the coverage of Other Dependents must be considered when determining that the self-support requirements of section 4216(c) have been met.

(iii) As part of the insurer's efforts to avoid substantial adverse selection, the insurer may include in the policy/certificate an eligibility provision which delays coverage for spouse and children (not newborn) who are hospital confined. The policy/certificate may also contain a provision which commences coverage on newborns 14 days after birth. After the 14-day delay, newborns must be covered even if they continue to be hospital confined. (Note: these delays are permissible only for life insurance benefits. Delays are not permissible for Accident and Health benefits. Section 4235(f).)

6. Eligibility Requirements

(a) Pursuant to Section 3220(a)(9) of the Insurance Law, all new employees of an employer or members of the labor union or other association or eligible group or classes eligible for such insurance must be added to such groups or classes for which they are eligible.

(b) For employer/employee groups described in §4216(b)(1) of the Insurance Law, classes must be determined by conditions pertaining to employment, or a combination of conditions pertaining to employment and conditions pertaining to family status.

(i) Conditions pertaining to employment include geographic situs, compensation, hours, and occupational duties. See Circular Letter 1963-4 Guidelines for Examination of Group Life Forms § I.B.2.

(ii) Age is not a condition pertaining to employment. Dudrey v. Equitable Life Assur. Soc. of U.S., 170 Misc. 418, 10 N.Y.S.2d 639.

(c) For labor union groups described in §4216(b)(2) of the Insurance Law, all of the members of such union, or all of any class or classes thereof determined by conditions pertaining to employment or conditions pertaining to membership in the union or combination of both, who are actively engaged in their occupation must be eligible for coverage.

(d) For multiple employer trust groups described in §4216(b)(4) of the Insurance Law, all of the employees of the employers, or all of the members of the unions, or all of any class or classes determined by conditions pertaining to employment, or to membership in unions, or both must be eligible for coverage.

(e) For employer trade association groups described in §4216(b)(5) of the Insurance Law, all of the employees of the participating employers eligible for insurance, or all of any class

or classes thereof determined by conditions pertaining to employment must be eligible for coverage.

(f) For association groups described in §4216(b)(10) of the Insurance Law, all members who have not attained any limiting age are eligible, or all such members and their employees, or all of any class or classes thereof determined by conditions pertaining to their employment or association membership or both must be eligible for coverage.

(g) Initial coverage and applied for increases in coverage may be subject to evidence of insurability requirements.

(h) An active work eligibility requirement is acceptable for coverage based upon employment. The policy/certificate may establish a reasonable minimum number of hours per week required for eligibility. The Department would consider 40 hours per week or less to be reasonable.

(i) Denial of coverage based on past lawful travel is not permitted. Section 2614.

(j) Citizenship may not be used as an eligibility factor. Section 2606.

7. Amounts Of Insurance

(a) Amounts of insurance must preclude individual selection by employees, policyholders, employers, or unions. Section 4216(b).

The maximum coverage for an individual employee, or limited number of employees, under a group contract must be reasonably related both to the total amount of insurance on the group and to the average amount of insurance on each member of the group. See Circular Letter dated July 19, 1962 and C.L. 63-4 §I.B.3 of the Guidelines For Examination Of Group Life Forms.

(b) A limited number of selections by employees or member are permitted if the selections offered utilize a consistent pattern of grading the amounts of insurance for individual group members so that the resulting pattern of coverage is reasonable. Section 4216(b). This issue is often best addressed through the explanation of variable material. The explanation should indicate the nature of the choices that will be offered (i.e. multiple of salary, specified amount, specified contribution) and the range of the choices.

(i) Fully underwritten plans can offer an unlimited number of selections.

(c) The group policy must indicate whether, and if so when (e.g., automatic increases in basic coverage under specified circumstances versus elective increases in supplemental coverage), increases in face amount will be allowed only subject to evidence of insurability.

8. Nonforfeiture Provision

(a) Section 3220(a)(11) of the Insurance Law provides that if a policy is in whole or in part on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision that is equitable to the insured persons and to the policyholder. The policy need not, however, contain the same nonforfeiture provisions that are required for individual life insurance policies.

(b) Individual nonforfeiture standards will be considered but not controlling. For example, paid-up insurance purchased by an employer need not provide for cash values. Any deviation from individual standards would require the prior approval of the superintendent.

9. Age-Based Reductions

(a) Group life policies often provide for a reduction in benefits for active employees who reach a certain age, commonly 65 or 70, due to the high cost of providing benefits for older employees.

(b) Any reduction schedule should be offered in a manner that will permit the policyholder to comply with the Age Discrimination in Employment Act.

10. Arbitration

Binding mandatory arbitration provisions are not permitted. Section 3201(c)

11. Discretionary Clauses

(a) Discretionary clauses are policy form provisions which grant an insurer or plan administrator or claims administrator the unrestricted authority under an insurance policy to determine eligibility for benefits, resolve disputes or interpret the terms and provisions of a policy or certificate, or reserves the right to an insurer, plan administrator or claims administrator to develop standards of interpretation or review. The Department believes that the use of discretionary clauses is contrary to sections 3201(c) and 4308(a) and Article 24 in that the provisions encourage misrepresentations and/or are unjust, unfair, inequitable, misleading, deceptive or contrary to law or to the public policy of this state. Circular Letter 14 (2006).

(b) Discretionary clauses will be reviewed on a case-by-case basis in accordance with Circular Letter 14 (2006) and subsection (a) above. Accordingly, any policy form containing a discretionary clause may not be submitted to the Department for approval under a certified procedure. Examples of discretionary clauses that the Department has found and/or would find to be contrary to section 3201(c), 4308(a) and/or Article 24 include but are not limited to:

(i) "The company (or plan/claims administrator) has full, exclusive, and discretionary authority to determine all questions arising in connection with the policy, including its interpretation."

(ii) "When making a benefit determination under the policy, the company (or plan/claims administrator) has the discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy."

(iii)"The insurer, as the claims administrator for life insurance benefits, has the discretionary authority to determine benefit eligibility, construe the terms of the plan and resolve any disputes which may arise with regard to the rights of any person under the terms of the plan, including but not limited to eligibility for participation and claims for benefits."

12. Permitted Exclusions

Section 3203(b) and (c) of the Insurance Law identifies permissible exclusions and restrictions of liability for individual life insurance. Regulation 62 sets forth permissible exclusions and restrictions of liability for accident and health benefits. In the absence of any guidance in §3220, we have permitted insurers to utilize the §3203(b) and (c) exclusions in the Group Life Insurance context, notwithstanding §3203(e). We have also, on a limited basis as set forth below, permitted some of the Reg. 62 exclusions to be used in group life insurance.

13. Specified Country Exclusion

(a) A life insurance policy may exclude or restrict liability in the event of death occurring while the insured is resident in a specified foreign country or countries. Such an exclusion must have a sound underwriting basis and be nondiscriminatory. Section 3203(b)(1).

(b) Any life insurance policy form containing any travel exclusion or restriction cannot be approved for delivery or issuance in this state unless disclosure required under Section 3201(c)(4) is set forth on the form's face page.

14. Suicide

(a) An insurer may exclude payment of the death benefit if the insured commits suicide within the first two years in accordance with Section 3203(b)(1)(B) or if the insured dies as a result of an intentionally self-inflicted injury within the first two years. The policy may provide an exclusion for suicide or intentionally self-inflicted injury within two years of the effective date of any increase in death benefits applied for by the policyholder or certificate holder subsequent to the policy issue date.

(b) The insurer must refund the premiums paid (less dividend paid in cash and any indebtedness) during the two-year period. Section 3203(b)(3) and Circular Letter 1963-4 § III.E.4.

(c) The phrase "while sane or insane" is prohibited, except with respect to additional accidental death benefits. Circular Letter 1963-4 § II.I.1.

(d) Any policy issued as a result of a conversion option must indicate that the two-year suicide/intentionally self-inflicted injury exclusion period does not start anew, but is effective as of the date of the original coverage. Circular Letter 1963-4 § II.H.6.

(e) Any policy issued to provide ported coverage must indicate that the two-year suicide/intentionally self-inflicted injury exclusion period, if any, runs from the date of the original coverage.

15. War and Service in Armed Forces Exclusion

(a) A life insurance policy may exclude or restrict liability in the event of death as a result of the following: (See Section 3203(c).)

(i) war or act of war, if the cause of death occurs while the insured is serving in any armed forces or attached civilian unit and death occurs no later than six (6) months after termination of such service.

(ii) the special hazards incident to service in any armed forces or attached civilian unit, if the cause of death occurs during the period of such service while the insured is outside the home area, and if death occurs outside the home area or within six months after the insureds return to the home area while in such service or within six months after the termination of such service, whichever is earlier.

(iii) war or act of war, within two years from the date of issue of the policy (or certificate), if the cause of death occurs while the insured is outside the home area but is not serving in any armed forces or attached civilian unit, and death occurs outside the home area or within six (6) months after the insured's return to the home area.

(b) The war exclusion is not to be construed as an exclusion because of status of the insured as a member of any armed forces or attached civilian unit or because of presence of the

insured as a civilian in a combat area. The exclusion does not exclude deaths due to diseases or accidents that are common to the civilian population and are not attributable to special hazards to which a person serving in such forces or units exposed in the line of duty.

(c) Any war exclusion must terminate six months after (the first to occur):

(i) the end of the war;

(ii) the discharge, release, or separation of the insured from active military service,

(iii) demobilization of the insured, or

(iv) the insured permanently leaves the war area.

(d) Any life insurance policy form containing any war exclusion or restriction (including eligibility restrictions) cannot be approved for issuance or delivery in this state unless disclosure required under Section 3201(c)(4) is set forth on the form's face page. Disclosure must also be provided in the application. Section 45.1 of Regulation 19 and Circular Letter 6 of 2003.

(e) Note that Section 336 of the Insurance Law requires insurers to notify the Superintendent prior to commencing the issuance of life insurance policies with war risk exclusions. See L.1991, c.467, § 27.

16. Aviation Exclusion

(a) A policy may exclude or restrict liability in the event of death resulting from aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline. Section 52.16(c)(4)(iii) of Regulation 62

(b) The parameters of the aviation exclusion or restriction must be specified in the policy and certificate. Section 3203(b)(1)(C)

17. Hazardous Occupations Exclusion

(a) A policy may exclude or restrict liability in the event of death resulting from hazardous occupations specified in the policy, provided that death must occur within two years from the date of issue. Section 3203(b)(1)(D)

18. Extra-hazardous activities

(a) A policy may exclude or restrict liability in the event of death resulting from extra-hazardous activities.

(b) If such an exclusion or restriction is included, it must provide a definition of "extra-hazardous activities". The definition may include aviation and related activities, such a sky-diving and parachuting and participation as a professional in athletics or sports. See section 52.2(i) of Regulation 62. We would consider inclusion of other activities on a case by case basis.

19. Other Exclusions

(a) The Department has not permitted the following exclusions:

(i) Exclusions due to medical conditions,

(ii) Exclusions due to terrorism

(b) If the group policy is issued pursuant to the NY Volunteer Firefighter's Benefit Law, the policy must exclude:

(i) Death while in the line of duty resulting from intoxication of the volunteer firefighter,

(ii) Death in the line of duty resulting from the willful intention of the volunteer firefighter to bring about the injury or death of himself or another. NY Volunteer Firefighter's Benefit Law §§1, 6, and 8.

G. Additional Benefits

1. Accelerated Payment of Benefit

See Accelerated Payment of Death Benefit outline on Department's website and Regulation 143 (11 NYCRR 41), Section 3230, Section 3201(c)(12)(A), and Section 1113(a)(1)(A)-(D).

2. Disability Benefits

(a) Types of Benefits

(i) Waiver of Premium/ Extended Death Benefit – Provides continuation of life insurance coverage under the group policy with no premium payment required. The policy and certificate must:

(I) state whether there is a waiting period before the benefit becomes effective. That waiting period may be up to 12 months.

(II) state whether or not premiums must continue to be paid during any waiting period and who (e.g., employer or employee) pays the premium. The policy/certificate must also indicate whether the benefit is retroactive at the end of the waiting period (i.e., whether premiums paid are refunded).

(III) explain whether or not the death benefit will be paid if the individual dies during the waiting period. We have approved provision whereby a death benefit will be paid during the waiting period where the individual was continuously disabled until the time of death.

(IV) identify the duration of the benefit.

(V) state that when the waiver is in effect, the insurer may not terminate coverage on the insured even if the group policy terminates.

(VI) describe how the benefit interacts with the conversion benefit. For example, there should be a description of the impact, if any, on the disability benefit as a result of the insured having exercised conversion during the waiting period. We have permitted provisions which provide that in order to take advantage of the disability benefit the insured must return, for a refund of premiums paid, any conversion policy that was issued by the company as a result of the insured exercising the conversion right during the waiver of premium waiting period.

(VII) state that the right of conversion is available to the insured if the waiver of premium/extended death benefit terminates.

(ii) Maturity Value Benefit – Provides for the payment of all or a portion of the face amount of an insured's life insurance in monthly installments upon the disability of the insured. The face amount of insurance must be reduced by the amount of the

benefit paid. The policy and certificate must provide that when this benefit is in effect the insurer may not terminate coverage even if the group policy terminates.

(I) The provision should explain what effect the payment of the maturity value benefit will have on the amount of the death benefit.

(II) The provision should describe how any unpaid portion will be distributed in the event of the insured's death.

(iii) Coverage may also be continued for disabled individuals under a continuation option with premium payments not being waived. See the Continuation section of this outline.

(b) Review Standards:

In the absence of specific statutory guidance, the Department will exercise discretion pursuant to section 3201 when reviewing disability benefits. The following is intended to provide guidance relative to how the Department has exercised and/or would exercise its discretion when reviewing these benefits. We would consider alternative provisions on a case-by-case basis.

(i) Definition of total and permanent disability. The definition should explain what is required for a disability to be considered "total". The definition should also explain what is required for a disability to be considered "permanent".

(ii) Notice of Claim – The provision should indicate that written notice of claim be given to the insurer during the lifetime of the insured and during the period of total disability and that failure to give such notice will not invalidate or reduce any claim if failure to give such notice was given as soon as reasonably possible.

(iii) Proof of Claim Requirements – The provision should set forth reasonable requirements as to the time, method and form of proof of disability and continuance of disability. The provision should state that failure to furnish proof of disability within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(iv) Permissible exclusions. Exclusions from paying disability benefits due to terrorism are not permitted. We would consider exclusions for the disability benefit that are the same as the exclusions for the underlying death benefit, where appropriate.

(c) Terms and Conditions

(i) The disability must commence while the employee is insured under the group policy.

(ii) The provision may provide that disability must commence prior to a specified age in order to qualify for the benefit.

(iii) Waiver of premium and extended death benefit must continue even if the group policy terminates. The benefit must continue for the same duration and under the same terms as it would have had if the group policy had not terminated. Circular Letter 1963-4 Guidelines for Examination of Group Life Forms § I.B.9.

3. Waiver of Premium for Unemployment Benefit

The Waiver of Premium for Unemployment benefit provides lapse protection in the event of unemployment as authorized under Section 1113(a)(1) and Section 3201(c)(12). Minimum

standards for unemployment lapse protection benefit levels, benefit eligibility and exclusion, premium level, advertising and disclosure are set forth in Regulation 174 (11 NYCRR 46).

(a) Terms and conditions relating to the benefit and the application therefore shall be approved policy forms.

(b) In addition to meeting the applicable requirements of Regulation 34-A (11NYCRR 219), advertising materials regarding an unemployment lapse protection benefit must comply with the requirements set forth in Section 46.5 of Regulation 174.

(c) In the case of a certificate issued under a group life insurance policy other than a noncontributory policy, the unemployment lapse protection benefit shall be offered only as an optional benefit with an identifiable charge therefore set forth separately from all other premiums/charges in the application form, policy and certificate schedule pages, and if applicable, the rider and endorsement forms. If the unemployment lapse protection benefit is offered as a rider or endorsement to in-force coverage, the rider or endorsement or schedule shall set forth the effective date of the benefit. Section 46.6 of Regulation 174.

(d) Policy and certificate provisions required for unemployment lapse benefit under Section 46.7 of Regulation 174 include the following:

(i) description of the types or causes of unemployment covered;

(ii) conditions of eligibility for coverage, which may include the following:

(I) a requirement that the insured be actively at work on a full-time basis (i.e. a specified minimum number of hours no greater than 30 hours per week) on the date of application or issue, or prior to the date of application or issue for a minimum period not exceeding 12 months;

(II) a requirement that the insured has not received or been eligible to receive a state or federal unemployment benefit for a minimum period of time -- not exceeding 12 months -- prior to the date of application or issue; and

(III) a requirement that the insured be an eligible age -- provided that the maximum age shall not be less than 65 -- on the date of application or issue.

(iii) statement of when, after commencement of involuntary employment, life insurance coverage first becomes protected from lapse and, if applicable, that required premiums must be paid by insured until such time;

(iv) description of where notice of claim forms can be obtained or, if no claim form is required, the information required for such notice of claim, together with the address where such notice must be delivered;

(v) description of any document or other information needed to serve as proof of unemployment;

(vi) description of the conditions or circumstances that must occur to make a claim for the unemployment lapse protection benefit. Such conditions or circumstances may include the following requirements:

(I) insured actually receive or be eligible to receive state or federal unemployment benefits for a specified period of time;

(II) occurrence of specified type or cause of insured's unemployment;

(III) life insurance coverage be in effect a minimum period of time before any payments are payable; provided that if the minimum period of time exceeds one year, no identifiable charge of the unemployment lapse protection benefit may be collected until the expiry of this period;

(IV) notice of claim and proof of unemployment be provided within reasonable period of time after commencement of period of unemployment;

(V) insured be unemployed for a minimum specified period not to exceed 180 days.

(vii) description of coverage to which unemployment lapse protection benefit applies (e.g., basic life, supplemental life, dependent coverage, etc.) if benefit does not apply to all coverages provided under the policy;

(viii) description of each basis for excluding or denying a benefit claim, which may include the following:

(I) voluntary separation from employment, without good cause (as term is defined in Section 593 of Labor Law);

(II) retirement;

(III) loss of income due to disability caused by accident, sickness, disease or pregnancy;

(IV) loss of income due to termination of employment as a result of willful misconduct (as defined in policy form), criminal misconduct or unlawful behavior as determined in judicial or administrative proceedings;

(V) strikes, lockouts, illegal walkouts, and industrial controversy (as such term is defined in Section 592(1) of the Labor Law); and

(VI) normal or routine scheduled layoff or plant closing where the employee is expected to be rehired.

(ix) if eligibility for benefit is dependent of being eligible for state or federal unemployment benefit, the following prominent statement or its equivalent:

Your eligibility for this coverage is dependent on your being eligible to receive state or federal [as appropriate] unemployment benefits. A change in your employment may affect your eligibility for benefits. If you have any questions you should contact the insurance company.

(x) a prominent statement of the extent to which receipt of the benefit may be considered taxable income;

(xi) an application question or statement corresponding to each benefit eligibility condition;

(xii) if insured becomes re-eligible for maximum benefit after a period of receiving benefits, a statement of conditions (not more stringent than initial eligibility conditions, with no more than a 12-month actively at work requirement) required to become re-eligible for full benefit. If insured has not satisfied the re-eligibility requirement at time of subsequent unemployment, such unemployment shall be considered a continuation of

the prior unemployment with no waiting period and with a maximum benefit equal to the unused portion of the maximum benefit period for the prior unemployment.

(xiii) if no re-eligibility feature is built into the benefit design, a provision regarding notice to be provided that benefits have ended, including statement of the amount of any unused portion of the benefit and the premium therefore;

(xiv) description of bases for benefit termination, which may include the following:

(I) coverage continues as paid-up insurance;

(II) policy termination or cancellation prior to termination of employment;

(III) insured reaches specified maximum age, which shall not be less than age 66;

(IV) policy is surrendered or lapses; and

(V) specified maximum benefit has been paid.

Note: Termination of group policy shall not cause the insured's certificate to terminate while benefit or waiting period therefore is in effect.

(xv) if policy also provides waiver of premium for disability benefit or other disability-related benefits, a provision specifying how benefits interact with unemployment lapse protection benefit.

(e) Premium rates for benefit must be filed with the Superintendent and must be reasonable in relation to the benefit provided as described in Section 46.8 of Regulation 174.

(f) If the policy provides for flexible premium payments, the maximum amount of premium waived for a period shall not exceed the greater of the smallest premium that will keep the policy from lapsing until the end of that period and the amount of premium needed to satisfy the no-lapse guarantee, if any, that expires next. See Section 46.9 of Regulation 174.

(g) If the continuation of the group life insurance is dependent on the employment of the insured, an unemployment lapse protection benefit may not be written in conjunction with group life insurance unless the group life coverage is reinstated once any waiting period is satisfied. As a condition of reinstatement, the group policy may require the surrender of any conversion policy obtained by the insured based on the termination of the group life insurance. See Section 46.10 of Regulation 174.

(h) Notwithstanding any actively at work requirement contained in the group policy, a group policy may allow for group life coverage to continue during the lapse protection benefit waiting period provided the policy/certificate language is clear regarding who (i.e. policyholder and/or certificate holder) is responsible for the payment of premiums during the waiting period. See Section 46.10 of Regulation 174.

4. Additional Death Benefits

These benefits are a special public policy exception to the general rule that both health and life insurance coverages must be broad-based and not dependent on the manner in which a disease, injury or death occurs.

To be considered life insurance the benefit must be in addition to, not in lieu of the general death benefit amount.

(a) Seat Belt Benefit

(i) Definition

This benefit provides for an additional death benefit if the insured dies as a result of accidental bodily injuries sustained in a motor vehicle accident while wearing a seat belt.

(ii) Coverage

To be considered life insurance the amount of coverage is limited to 10% of the death benefit in a group life policy.

(b) Common Carrier Benefit (Public Transportation Benefit)

(i) Definition

Provides a benefit if the insured dies as a result of a covered accident while a fare-paying passenger on a train, plane, bus, boat or other commercial carrier.

(ii) Coverage

To be considered life insurance may not be for an amount in excess of five times the face amount of the policy.

(c) We have not permitted the payment of additional death benefits to be considered life insurance in the following instances because they are too limited:

(i) Felonious Assault Benefit.

(ii) Day Care Benefit.

(iii) Education Benefit.

5. Accidental Death and Dismemberment

AD&D benefits are accident and health insurance under Section 1113(a)(3) of the Insurance Law and must be submitted to the Health Bureau of the Department in accordance with II.C.2 above.

6. Accidental Death

Accidental death (AD) benefits are an additional benefit under life insurance policies pursuant to Section 1113(a)(1) of the Insurance Law and may be submitted to the Life Bureau as an additional benefit under a life insurance policy. This contract feature will be reviewed for compliance with section 52.9, 52.16 and 52.18 of Regulation 62. (See especially, Sections 52.9, 52.16, and 52.18 of Reg. 62.) Exclusions from paying accidental death benefits due to terrorism are not permitted. Section 52.16(c) of Reg. 62 provides for the only permissible accidental death exclusions.

IV. Group Requirements

A. Eligible Groups

1. Insurer Responsibilities

(a) It is the insurer's responsibility to determine whether the definitional requirements in Section 4216(b) for an eligible group are satisfied at the time of issue and thereafter.

(b) The insurer should determine whether

(i) All employees or members eligible are covered where the coverage is non-contributory;

(ii) Classifications of employees or members is by conditions pertaining to employment, family status, membership in the association or union;

(iii) Individual selection is precluded or limited number of selections is reasonable;

(iv) Minimum number and minimum participation requirements are satisfied where the coverage is contributory;

(v) The policyholder is not the beneficiary, except in §3205(d) cases or with respect to dividends;

(vi) Trust requirements satisfied, where applicable, including "established by" or "participated in" requirement.

(vii) Seasoning and purpose requirements. Typically, the group must have been in existence for at least two years and formed for purposes principally other than obtaining insurance.

(viii) With respect to the groups described by 4216(b)(12), (13) and (14) and out-of-state nonrecognized groups, the premiums charged must be reasonable in relation to the benefits provided. See Regulation 123.

(I) Where the group policy is delivered or issued for delivery in NY, the loss ratio requirements of Regulation 123 apply to the group policy as a whole.

(II) Where the group policy is delivered outside of NY, the loss ratio requirements of Regulation 123 apply to the subset of certificates deemed delivered in NY pursuant to §3201.

(ix) See comparative bid requirement applicable to multiple employer trust groups with respect to union.

(x) See Circular Letter No. 4 (1957) Code of Ethical Practices With Respect to the Insuring of the Benefits of Union or Union-Management Welfare and Pension Funds

2. Recognized Groups

(a) Employer/Employee Group – Section 4216(b)(1)

(b) Labor Union -- Section 4216(b)(2)

(c) Creditor/Vendor Group – Section 4216(b)(3). Must comply with Regulation 27-A See also Credit Insurance product outline.

(d) Multiple Employer Trust -- Section 4216(b)(4)

(i) Same Industry

(ii) Different Industry

(e) Trade Association Group -- Section 4216(b)(5)

(f) CSEA -- Section 4216(b)(6)

(g) Police & Firefighters -- Section 4216(b)(7)

(h) Municipal corporation or public housing authority -- Section 4216(b)(8)

(i) Managerial or Confidential Employees -- Section 4216(b)(9)

(j) Professional Association -- Section 4216(b)(10)

(k) National Guard -- Section 4216(b)(11)

(l) Affinity Association Group -- Section 4216(b)(12). Must comply with Regulation 123.

(m) Financial Institution Groups -- Section 4216(b)(13). Must comply with Regulation 123.

(n) Discretionary Groups -- Section 4216(b)(14). Must comply with Regulation 123.

(i) In seeking approval of a discretionary group, the company must show that

(I) There is a common enterprise or economic or social affinity or relationship;

(A) The group should not have been founded primarily for the purpose of obtaining insurance.

(II) The premiums charged are reasonable in relation to the benefits provided; and

(III) The issuance of the policy would result in economies of acquisition or administration, would be actuarially sound, and would not be contrary to the best interest of the public.

(A) The discretionary group should not be used by a group that would otherwise qualify as a recognized section 4216(b) group in order to circumvent statutory requirements pertaining to that recognized group.

(ii) The following have been accepted as qualifying pursuant to Section 4216(b)(14):

(I) Customers of a Life Insurance Brokerage firm specializing in corporate-owned life insurance.

(II) Group policy issued to a college to cover full-time students of the college. The full-time students are the certificate holders.

(III) Group policies issued to Intergovernmental Relations Councils as described in section 239-n of New York General Municipal Law based on the public policy and legislative intent behind section 239-n as stated in section 1 (c) of Article IX of the New York State Constitution.

(iii) The Department has not accepted the following:

(I) Financial Services & Advisory Services Organization because it would mean circumventing section 4216(b)(13).

(II) A group of doctors and other health care providers, where the participating providers would have qualified under section 4216(b)(2).

(III) A group consisting of children or grandchildren of members of an association where the children and grandchildren were not members of the association because there was not a common enterprise or economic or social affinity or relationship.

(iv) The forms to be used with the proposed discretionary group may not be submitted via a certified process until the superintendent has exercised discretion under §4216(b)(14) and approved the group. A pre-submission inquiry may be submitted to the Department seeking approval of the group as a discretionary group.

B. Non-Recognized Groups

Groups that fail to satisfy the definitional requirements in Section 4216(b) of the Insurance Law are not recognized groups under the Insurance Law. Such group life policies cannot be delivered in this state. However, certificates covering New York residents under group policies

delivered outside of New York will be deemed to be delivered in this State pursuant to Section 3201(b)(1) and are subject to the requirements of Regulation 123. (11 NYCRR 59).

C. Extraterritorial Jurisdiction

1. Group Life Certificates Deemed to be Delivered in New York

(a) Pursuant to Section 3201(b)(1), certificates evidencing insurance coverage on a resident of this state are deemed to be delivered in this state, regardless of the actual place of delivery, where the master policies or contracts were lawfully issued without this state in a jurisdiction where the insurer was authorized to do an insurance business, if the insured group is one of the following:

(i) Different-Industry Multiple Employer Trust Groups-Section 4216(b)(4) where the employer is principally located in New York. The use of the Standard Industrial Classification (SIC) Manual Codes or the North American Industry Classification System (NAICS) classifications are inappropriate to determine "same industry."

(ii) Association Groups-Section 4216(b)(12)

(iii) Financial Institution Groups-Section 4216(b)(13))

(iv) Discretionary Groups-Section 4216(b)(14)

(v) Group Not Specifically Described in Section 4216(b).

(b) Purpose of the Section 3201(b)(1) Extraterritorial Jurisdiction Provision - The purpose of extraterritorial jurisdiction is to extend the basic protection of New York law and regulations to residents of the state when they purchase insurance coverage through out-of-state group arrangements where the individual insured has no close association or affiliation with the group policyholder.

(c) Recognized Group Certificates. Pursuant to §59.4(a) of Regulation No. 123, certificates evidencing coverage under a policy delivered outside of New York to a group recognized under New York law must "afford insureds protections substantially similar" to those provided by group policies and certificates actually delivered in New York. Certificates must include or satisfy:

(i) all mandated coverages at reasonable levels, not necessarily at the same level prescribed by law;

(ii) conversion and continuation rights;

(iii) cannot include a prohibited provision or benefit;

(iv) minimum benefit ratio standards.

(d) Non-Recognized Group Certificates. Pursuant to §59.4(a) of Regulation No. 123, certificates evidencing coverage under a policy delivered outside of New York to a group not recognized under New York laws must comply with the contract and loss or benefit ratio requirements of individual or group insurance whichever affords the certificate holder the greatest protection. The contract standards and loss or benefit ratio standards may not be the same.

(e) Group Life Insurance Benefit Ratio for Contributory Coverage. Section 59.5 of Regulation No. 123 generally requires a 60% minimum benefit ratio for term life insurance and an actuarial memorandum demonstrating that the minimum benefit ratio will be met for a period of 10 years must be filed. The minimum benefit ratio will be 5% higher or lower depending on the expected average annual premium.

(f) Monitoring Requirement - Detailed reporting and monitoring standards are provided to ensure compliance with the rate regulation. The insurer is expected to cure any deviation from the minimum ratios by corrective plan of rate reductions, benefit increases or refunds to insureds. Section 59.7 of Regulation No. 123.

(g) The benefit ratio and monitoring requirements in Section 59.5 and Section 59.7 apply to certificates delivered in New York under groups described in Section 4216(b)(12), (13) and (14) as well as certificates deemed to be delivered in this State.

2. Out-of-State Group Insurance Business of Insurers

(a) Domestic Insurers

(i) Section 3201(b)(2) as revised in 2006 no longer requires group life insurance policy forms issued by a domestic insurer for delivery outside the state to be filed with the superintendent.

(ii) Section 3201(c)(6)(a) provides that the superintendent may disapprove any policy form issued by a domestic life insurer or fraternal benefit society for delivery outside the state if its issuance would be prejudicial to the interest of its policyholders or members.

(iii) Section 3201(c)(6)(b) providers that except for the policy forms specified in Section 3201(b)(2), every domestic insurer and fraternal benefit society shall file annually with the Superintendent a list identifying and describing the policy forms issued by the insurer or fraternal benefit society for delivery outside the state in a form prescribed by the Superintendent. If the Superintendent determines that the issuance of a policy form has been or may be prejudicial to policyholders or members, the Superintendent may take any action he or she deems appropriate, including issuing an order, after hearing, to cease and desist issuing the policy form.

(b) Foreign Licensed Insurers

(i) Generally, we do not review the out-of-state group insurance business of foreign licensed insurers, especially if no New York residents are covered. However, such coverage may be subject to Section 1106 constraints if the coverage is prejudicial to the interests of policyholders. The requirement of Section 4216(c) that each group policy issued be expected to be self-supporting would apply.

(ii) We generally apply comity principles and follow the group exception to the mail order prohibition with respect to out-of-state group business which covers New York residents, except as modified by §3201(b)(1).