Group Disability Income Insurance Checklist for SERFF Filings (As of 12.1.20)

Instructions for SERFF Checklist

A. For **ALL** filings, the "General Requirements for All Filings" section must be completed.

B. For a **FORM** filing, completion of additional sections may be required as follows, depending on the type of form being submitted:

- Policy: Complete the "Policy Forms" section.
- Rider or Endorsement: Complete all items in the "Policy Forms" section relevant to the form being submitted.
- Application: Complete the section entitled "Application Forms."

C. For filing of initial rates, complete the section entitled "Actuarial Section For New Product Rate Requirements" in addition to completion of the applicable form sections identified above. For filing of rate changes to existing products (increases, decreases, or change in rate calculation rules or procedures), complete the "Actuarial Section for Existing Product Rate Requirements" section. For filing of any other changes to rate or underwriting manuals (e.g., changes in commissions or underwriting), complete the "Actuarial Section for Existing Product Rate Requirements" section.

D. For each item, enter in the last column the form number(s) and page number(s) where the requirement is met in the filing.

E. **Instructions for Citations:** All citations to Department regulations link to the Department of State website and an unofficial copy of the NYCRR. Select title 11 for Department regulations. Most of the pertinent form and rate regulations are located in Chapter III Policy and Certificate Provisions, Subchapter A Life, Accident and Health Insurance. All citations to New York Laws (Insurance Laws or other New York laws) link to the public LRS website. To locate the Insurance Laws, select the link labeled "ISC."

LINE OF BUSINESS:	Group Health - Disability Income	LINE(S) OF INSURANCE	CODES
CODE:	H11G	Short Term	H11G.002
	H11G	Long Term	H11G.003
	H11G	Other	H11G.004
	H11G	Combined Short Term and Long Term	H11G.005
	H11G	Statutory Disability Benefits Law Coverage	

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
GENERAL REQUIREMENTS FOR ALL FILINGS	*Note: Unless otherwise noted, all references are to Insurance Law, Insurance Regulations, and Department Insurance Circular Letters and Office of General Counsel ("OGC") opinions*	*Note: This checklist is intended to provide guidance in the preparation of policy forms for submission and is not intended as a substitute for statute or regulation.*	
Filing Description in SERFF	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	The SERFF filing description must contain the following: • The identifying form number of each form submitted. § 52.33(a) • If the form being submitted is a policy, the filing description must indicate that the policy is submitted pursuant to 11 NYCRR 52.8. § 52.33(b) • Whether the form is new or supersedes an approved or filed form. § 52.33(c) • If the form supersedes an approved or filed form, the filing description must state the form number and date of approval or filing of the superseded form and any material differences from the superseded form. § 52.33(d) • If the approval of the superseded form is still pending, the filing description must include the state tracking number, form number, and the submission date. § 52.33(d) • If the form had previously been submitted for preliminary review, the filing description must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission or the differences from the form submitted for preliminary review. § 52.33(e) • If the form is submitted in accordance with 11 NYCRR 52.32(c), the filing description must identify the prefiled group coverage. § 52.33(f) • If the form is other than a policy, the filing description must identify the form number and approval date of the policy or policies with which it will be used. If the form is for general use, the Department may accept a description of the type of policy with which it may be used in lieu of the form number and approval date. § 52.33(g) • If the form is a policy, the filing description must identify the form numbers and dates of approval of any applications previously approved to be used with the policy unless the application is required to be attached to the policy upon submission. § 52.33(h)	

		• If the policy is designed to be used with insert pages, the filing description must contain a statement of the insert page forms which must always be included in the policy and a list of all optional pages, together with an explanation of their use. § 52.33(i) *Note: SERFF filing descriptions should advise as to whether the policy is intended for internet sales..*	
Form Requirements	§ 3201(c) § 3217(b) 11 NYCRR 52.1(c) 11 NYCRR 52.31	Each form in the filing must meet the following requirements: • The form provisions are NOT misleading or unreasonably confusing. § 3217(b)(2), § 52.1(c) • The form provisions provide substantial economic value to the insured. § 3217(b)(5), § 52.1(c) • The form provisions are NOT unjust, unfair, inequitable, misleading, or deceptive to the policyholder. §§ 3201(c)(3), 3217(b) • The form contains no strikeouts. § 52.31(b) • The form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. § 52.31(d) • The form is submitted in the form intended for actual use. § 52.31(e) • All blank spaces are filled in with hypothetical data. § 52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. A full explanation of the nature and scope of the variable material, contained in an Explanation or Memorandum of Variable Material, should be uploaded to the Supporting Documentation tab in SERFF. § 52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable if suitably indicated by red ink, bracketing or underlining, and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as "will conform to law" or "as requested by policyholder" to describe the variable material. § 52.31(l)	
Flesch Score	§ 3102(c)	Provide Flesch score certification (the Flesch score should be at least 45). The number of words, sentences and syllables in the policy form should be set forth as part of the certification, which must be signed by an officer of the company.	
Group Status and Recognition	§ 4235 § 3201(b)(1) 11 NYCRR 59	The SERFF filing description should include a statement that policy forms will be sold to a group specified in Insurance Law § 4235(c)(1). However, a more detailed statement must be included where discretionary group status is sought under Insurance Law § 4235(c)(1)(M). See below. The size of the group should be indicated (small, large or both). The SERFF filing description should indicate whether the submission is for general use or is submitted on a single case basis. If the submission is for use on a one case basis, the group must be identified along with the subpart of Insurance Law § 4235(c)(1) in which the group fits and a confirmation that the group meets all of the requirements of the identified subpart. Requests for discretionary group recognition must be accompanied by written documentation that demonstrates that the proposed group meets every element stated in the named statute. The documentation must also make clear that the request for discretionary group recognition is not a subterfuge, evasion technique, or a marketing tool to avoid compliance with other statutory or regulatory requirements and recognized marketing mechanisms. This provision is not intended to allow approval of groups recognized in the various subparagraphs of Insurance Law §§ 4235(c)(1) or 4237(a)(3), but for which the proposed discretionary group does not meet one or more of the	

		requisites specifically required by Insurance Law §§ 4235 or 4237. The request for allowance of a discretionary group must be granted before a policy may be issued to a discretionary group. Pursuant to Insurance Law § 3201(b)(1) and Insurance Regulation 123 (11 NYCRR Part 59), an accident and health certificate is deemed delivered in New York and subject to the Department's review and approval regardless of the actual place of delivery, if the policy is issued to one of the following groups: • § 4235(c)(1)(D), a policy is issued to a trustee or trustees of a fund established, or participated in, by two or more employers not in the same industry with respect to an employer principally located within New York; • § 4235(c)(1)(K), a policy issued to an association; • § 4235(c)(1)(L), a policy issued to a bank, retailer or other issuer of a credit card to insure holders of the credit card; or a bank, savings and loan association, credit union, mutual fund, money market fund, stockbroker or other similar financial institution regulated by state or federal law to insure the depositors, account holders, or members of that financial institution; • § 4235(c)(1)(M), a policy issued to a discretionary group as approved by the Superintendent; or • Any groups not recognized in Insurance Law §§ 4235(c)(1) or 4237(a)(3). The group certificate is reviewed for compliance with New York Law. The group policy that is delivered out-of-state is not reviewed.	
Prefiled Group Coverage	11 NYCRR 52.32	A copy of the letter of confirmation sent to the policyholder by the insurer must be submitted to the Department within 30 days after the date the insurer agrees to provide insurance and must include the following: • The effective date of coverage. § 52.32(a)(1) • The nature and extent of the benefits or change in benefits as then known. § 52.32(a)(2) • That the contractual forms may be executed and issued for delivery only after filing with or approval by the Department. § 52.32(a)(3) • That if the forms are not filed or approved or are disapproved, the parties will be returned to the status quo insofar as possible, or the coverage will be modified retroactively to meet all requirements necessary for approval. § 52.32(a)(4) *Note: At the time the insurer agrees to provide insurance, it cannot have been reasonably possible to obtain approval prior to the effective date of coverage because the policyholder requested the insurer provide immediate coverage. Also, the actual forms must be submitted for approval within six months from the date the insurer agrees to provide insurance. Failure to meet any of the conditions within the time specified shall be a violation of the Insurance Law, unless reasons for delay, including its probable extent, satisfactory to the Department are submitted to the Department within the respective times specified.*	
Rider or Endorsement	11 NYCRR 52.16(e)(2) 11 NYCRR 52.18(g)(2) 11 NYCRR 52.31(a)	Except for riders by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders added to a policy after date of issue which reduce or eliminate coverage in the policy shall provide for signed acceptance by the policyholder. § 52.18(g)(2) New policy forms must comply with any statutory requirements without the use of amendatory riders or endorsements except for minor changes, where the minor changes are necessitated by	

		distinctive New York requirements. Previously approved policies may have a rider(s) attached to comply with changes in New York law, but only if the rider(s) does not cause the policy in its entirety to mislead or confuse the policyholder. § 52.31(a) *Note: For waivers issued as a condition of insurance, renewal or reinstatement, see 11 NYCRR 52.16(e)(2).*	
Table of Contents	§ 3102(c)(1)(G)	A table of contents is required for policies that are over 3,000 words or more than 3 pages regardless of the number of words.	
APPLICATION FORMS			Form & Page Number
Authorization	11 NYCRR 420.18 Circular Letter No. 8 (2017) 42 USC § 290dd-2 42 CFR § 2.31	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months. A written authorization that consents to a disclosure of substance use disorder records must include: (1) the specific name or general designation of the program or person permitted to make the disclosure; (2) the name or title of the individual or the name of the organization to which disclosure is to be made; (3) the name of the patient; (4) the purpose of the disclosure; (5) how much and what kind of information is to be disclosed; (6) the signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under 42 C.F.R. § 2.14 or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under 42 C.F.R. § 2.15 on behalf of the patient; (7) the date on which the consent is signed; (8) a statement that the consent is subject to revocation at any time except to the extent that the program or person that is to make the disclosure has already acted in reliance on it, where acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; and (9) the date, event or condition upon which the consent will expire if not revoked before that date, event or condition.	
Discrimination	§ 2606 § 2607 § 2608 § 2612 Circular Letter No. 3 (2016)	No insurer or entity shall refuse to issue any insurance policy, or cancel or decline to renew the policy or otherwise unfairly discriminate because of race, color, creed, national origin, disability, sex, marital status, status as a victim of domestic violence, or engage in sexual stereotyping. "Sex" includes sexual orientation, gender identity or expression and transgender status. No insurer or entity shall refuse to issue or renew, or shall cancel any insurance policy because of any past treatment for a mental disability of the insured. With respect to past treatment for a mental disability, an issuer may refuse to issue, renew, or cancel a policy if the issuer relies on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience.	
Electronic Application	§ 3201(c)(3) 11 NYCRR 52.1(c) State Technology Law Article III 9 NYCRR Part 540	If an insurer is seeking approval to use a previously approved paper application in electronic format, screen shots of the previously approved paper application must be filed for reference for informational purposes. Any drop downs, pop-ups, FAQs, or linked material that could appear in the application process must be included either within the screen shots or as a supporting document provided for informational purposes. If an insurer is seeking approval of an application not previously approved that will only be available in an electronic format (i.e., will be completed and signed electronically) and there is no corresponding paper application, then screen shots must be submitted for approval as the application form. In this case, the screen shots must contain a distinct form number in the lower	

		left corner and must comply with all applicable application requirements. Reflexive material, including drop down options, must be submitted for approval in a corresponding Explanation of Variable Material. Include any pop-ups, FAQs, or linked material that could appear in the application process as a supporting document provided for informational purposes. If an electronic signature is used, it must comply with the Electronic Signatures and Records Act (State Technology Law Article III) and associated regulations (9 NYCRR Part 540). The filing should describe the procedures for the use of electronic signatures.	
Electronic Delivery of Documents	State Technology Law Article III OGC Opinion No. 09-01-01 OGC Opinion No. 05-11-28	Before an insurer transmits policy forms or any other documents to an insured electronically, it must obtain the insured's consent. • If the electronic application includes a consent for the electronic delivery of documents, the opt-in to deliver documents electronically must be separate from the agreement to electronically purchase and/or electronic signature. • If the insured refuses to consent to receiving documents electronically, the insurer must send a hard copy of the policy forms or other documents to that insured. • If the insured refuses to consent to receiving documents electronically, the insurer should allow the insured the ability to proceed with submitting the application and purchasing the insurance electronically.	
Extra-hazardous Activities	§ 1113(a)(17)(E) 11 NYCRR 52.2(i) 11 NYCRR 52.16(e)(2)	If the application contains questions as to whether the applicant has engaged in or contemplates participation in a number of specified activities, the insurer will adhere to the following Regulation 62 guidelines regarding "extra-hazardous" activities, defined by 11 NYCRR 52.2(i) as aviation and related activities, such as sky diving and parachuting, and participation as a professional in athletics or sports. Participation as a professional in athletics or sports means an individual who would qualify for insurance under Insurance Law § 1113(a)(17)(E). An insurer may exercise the following options depending upon whether the activity engaged in by the applicant is an extra-hazardous activity as defined by 11 NYCRR 52.2(i). If the activity engaged in by the applicant is within the definition of an extra-hazardous activity, the insurer may elect one of four options: 1. The insurer may issue a standard risk policy; 2. The insurer may decline to issue any policy at all; 3. The insurer may place a waiver, approved by the Department, on the policy declining coverage for accidents arising out of such activities; or 4. The insurer may charge additional premiums for providing coverage for such activities. If the activity engaged in is not within the definition of an extra-hazardous activity, the insurer must issue a standard risk policy or decline to issue any policy at all. *Note: Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required, unless on initial issuance the full text of the extra-hazardous activity exclusion is contained either on the first page or specification page of the policy. For additional information, see the "Extra-hazardous Activities" section under "Permissible Exclusions and Limitations."*	
Fraud Warning Statement	§ 403(d) 11 NYCRR 86.4(a), (d)	The application form contains the prescribed fraud warning statement listed below. The fraud warning statement must be placed directly above the signature line and printed in such a way that it is conspicuous to the insured such as by using bold font or larger font size.	

		"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."	
Future Activities	11 NYCRR 52.1(c)	Applications should not inquire about open ended future activities or the future intent of the applicant (such as asking if the insured ever plans on leaving the country) as these are unduly speculative. Questions should be limited to present intent or present plans.	
Health Questions	11 NYCRR 52.51(b)	Any question of past or present health of any person that refers to a specific disease or general health must be asked "to the best of the applicant's knowledge and belief." This does not apply to questions about factual information such as doctor visits or hospital confinements. *Note: The application should phrase each question with respect to this statement; or, in the alternative, a sentence that states that "the following questions are asked to the best of the applicant's knowledge and belief." may be added to the beginning of any application section that includes questions regarding a specific disease or general health.*	
Investigative Consumer Report	General Business Law § 380-c	If an Investigative Consumer Report will be prepared or procured, a notice and authorization complying with General Business Law § 380-c is included in the application OR in a separate form.	
Medical Information Exchange Center	§ 321	If the insurer will transmit medical information from an applicant for personal insurance to a Medical Information Exchange Center (such as a Medical Information Bureau) or other similar facility, the insurer must provide a clear and conspicuous notice disclosing: • A description of the Medical Information Exchange Center or other facility and is operations, including its name, address and telephone number where it may be contacted to request disclosure of any medical information transmitted to it; • The circumstances under which the Medical Information Exchange Center or other facility may release such medical information to other persons; and • Such applicant's right to request the Medical Information Exchange Center or other facility to arrange disclosure of the nature and substance of any information in its files pertaining to them, and to seek correction of any inaccuracies or incompleteness of such information.	
Multiple Levels of Applications and/or Underwriting	§ 4224(b)	If more than one level of medical and financial underwriting (e.g., full underwriting, simplified underwriting, or guaranteed issue) is used for a policy, or multiple applications are used, attach a full explanation of: a. The various levels of underwriting; and b. The objective criteria used to determine the use of each level of underwriting.	
Pre-Existing Conditions	11 NYCRR 52.51(j) 11 NYCRR 52.54	If the application is used with a policy that contains a "pre-existing conditions" provision, a statement describing the policy provision is included in the application OR the statement is included in the disclosure statement required by 11 NYCRR 52.54 that is delivered at the time of application.	
Prohibited Questions and Provisions	§ 3204 11 NYCRR 52.51	The application does NOT contain: • Questions regarding the applicant's race. • A provision that changes the terms of the policy to which it is attached. • A statement that the applicant has not withheld any information or concealed any facts. • An agreement that an untrue or false answer material to the risk will render the policy void.	

		• An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to Insurance Law § 3204(d). • Questions regarding HIV, such as HIV testing, test results, or treatment. *Note: Information regarding the diagnosis or treatment of AIDS may be sought and used. The insurer has the right to review medical records or conduct its own medical records as part of the underwriting process. References to AIDS Related Complex (ARC) should also not be used as the terminology has been discontinued in the medical community.*	
Representations not Warranties	§ 3105 § 3204(c), (d)	Statements made on the application by the applicant are representations and not warranties, and only material misrepresentations can avoid a contract of insurance. No representation is deemed material unless knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to issue the policy. *Note: The insurer may make insertions to the application only for administrative purposes if the insertions are clearly not ascribed to the applicant. No other insertions or alterations of a written application will be made by anyone other than the applicant without the applicant's written consent pursuant to Insurance Law § 3204(d).*	
Telephone or In-Person Interview	§ 3204 State Technology Law Article III	If a telephone or in-person interview will be used with this application, the interview is conducted in the following manner: • Any questions raised during the interview are limited to those questions appearing on an application approved by the Department (i.e., questions over the phone would be no different than those being asked in the application); • The applicant must be provided with a written copy and will have an opportunity to review and make corrections to those statements that were attributed to him/her in the interview; • Any information obtained in the interview that will be used in the underwriting process will be reduced to writing, signed by the applicant and attached to the policy in compliance with Insurance Law § 3204; • If an electronic signature is used, it must comply with the Electronic Signatures and Records Act (State Technology Law Article III); and • If a telephonic application is being used, please provide a description of the procedure for taking a telephonic application. Any scripts used in the telephone interview must be filed for reference.	
Written Informed Consent for HIV Testing	§ 2611 Public Health Law § 2782 Circular Letter 3 (1989) Circular Letter 5 (1997)	No insurer or its designee shall request or require an applicant for insurance coverage to be the subject of an HIV related test without receiving the written informed consent of such individual prior to such testing and without providing general information about AIDS and the transmission of HIV infection. Written informed consent to an HIV related test shall consist of a written authorization that is dated and includes at least the following: • a general description of the test; • a statement of the purpose of the test; • a statement that a positive test result is an indication that the individual may develop AIDS and may wish to consider further independent testing; • a statement that the individual may identify on the authorization form the person to whom the specific test results may be disclosed in the event of an adverse underwriting decision, which person may be the individual or a physician or other designee at the discretion of the individual proposed for insurance;	

		• the Department of Health's statewide toll-free telephone number that may be called for further information about AIDS, the meaning of HIV related test results, and the availability and location of HIV related counseling services; and • the signature of the applicant for insurance, or if such individual lacks capacity to consent, the signature of such other person authorized to consent for such individual. *Note: In addition to compliance with the written informed consent under Insurance Law § 2611, the insurer has obligations under Public Health Law § 2782 regarding written informed consent, authorization and disclosure of confidential information regarding HIV testing.*	
POLICY FORMS			Form & Page Number
COVER PAGE			
Disclosure Statement	§ 3201(c)(3) § 3217(b)(5) 11 NYCRR 52.1(c) 11 NYCRR 52.54(c)(2)(v)	The following statement shall appear prominently in boldface type, in at least 14-point size but not less than the size of the type used for policy captions on the first page of the policy and certificate: The insurance evidenced by this certificate provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.	
Label	11 NYCRR 52.8	The policy form is labeled as "Disability Income Insurance" within the definition of 11 NYCRR 52.8.	
Insurer Name		The policy form contains the name and full address of the New York-licensed issuing insurer on the front or back cover.	
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy form (such as on the cover page).	
DEFINITIONS			
Complications of Pregnancy	11 NYCRR 52.2(e)	Complications of pregnancy is defined as conditions requiring hospital stays (when the pregnancy is not terminated) whose diagnosis is distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. Complications of pregnancy also includes nonelective caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.	
Health Care Professional to Diagnose or Treat the Insured, including Definition of Physician	§ 3201(c)(3) § 3217(b) 11 NYCRR 52.1(c) 11 NYCRR 52.1(d) 11 NYCRR 52.9	The policy form may define a licensed health care professional as an individual acting within the scope of his or her license that typically diagnoses or treats the insured's condition. If used, the policy form should define a "physician" as a licensed health care professional who diagnoses, treats, operates, or prescribes for any human disease, pain, injury, deformity, or physical condition. A licensed physician has completed a program of medical education and received the doctor of medicine (M.D.), doctor of osteopathic medicine (D.O.), or equivalent degree. The policy form may require that the insured be diagnosed with a disability by a physician, although for disabilities due to mental health or substance use disorders, the policy form should permit the insured to be diagnosed by another licensed health care professional able to diagnose mental health or substance use disorders within the scope of their practice.	

		Note: Policy forms should not unduly limit the insured's access to benefits by requiring that the insured seek care from a physician (meaning an MD or DO) when other licensed health care professionals may diagnose or treat the insured within the scope of their practice.	
Hospital	11 NYCRR 52.2(m)	"Hospital" means a short-term, acute, general hospital, that: • is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons; • has organized departments of medicine and major surgery; • has a requirement that every patient must be under the care of a physician or dentist; • provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.); • if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 USC § 1395x(k); • is duly licensed by the agency responsible for licensing such hospitals; and • is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitory care.	
Pre-Existing Condition	§ 3234 11 NYCRR 52.18(a)(5)	A "Pre-Existing Condition" is one for which medical advice was given, treatment was recommended by or received from a physician, within six months before the effective date of the insured's coverage.	
ELIGIBILITY			
Adopted Children and Step-Children	11 NYCRR 52.18(e)(2) 11 NYCRR 52.18(e)(3)	If dependent coverage is selected by the policyholder, the policy form provides that adopted children and stepchildren dependent upon the insured are eligible for coverage on the same basis as natural children. Further, a family policy covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child is eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	
Dependents	§ 4235(f)(1)(A) § 3221(a)(7)	If dependent coverage is selected by the policyholder, the policy form provides coverage of dependents, and states the age restrictions for the insurance provided. Dependents may include the employee/group member's spouse (see "Spouse" below), child(ren), or persons chiefly dependent upon the employee/group member. An employee/ group member's child is not required to be chiefly dependent upon the employee/group member for support and maintenance in order to be a dependent.	
Domestic Partners	§ 4235(f) OGC Opinion No. 01-09-11 OGC Opinion No. 01-11-23	The policy form may provide coverage for domestic partners, but such coverage is not required. In order to qualify as domestic partners, the insured must demonstrate proof of mutual economic interdependence evidenced as follows: 1. Registration as a domestic partnership in jurisdictions that have such registration; or 2. If no registration is available, then: a. An alternate affidavit of domestic partnership is required. The affidavit must be notarized and must contain the following: i. The partners are both 18 years of age or older and are mentally competent to consent to contract; ii. The partners are not related by blood in a manner that would bar marriage under laws of the State of New York; iii. The partners have been living together on a continuous basis prior to the date of the application;	

		iv. Neither individual has been registered as a member of another domestic partnership for at least the last six (6) months; b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and c. Proof that the partners are financially interdependent by submission of two (2) or more of the following: a joint bank account; joint credit card or charge card; joint obligation on a loan; status as an authorized signatory on the partner's bank account, credit card or charge card; joint ownership of holdings or investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on the lease of the shared residence; shared rental payments of residence (need not be shared 50/50); listing of both partners as tenants on a lease, or shared rental payments, for property other than residence; a common household and shared household expenses (need not be shared 50/50); shared household budget for purposes of receiving government benefits; status of one as representative payee for the other's government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses (need not be shared 50/50); execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy; designation as beneficiary under the other's retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; or other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.	
New Employees	§ 3221(a)(3)	New employees or members of the class must be added to the class for which they are eligible.	
Newborn Infants	§ 4235(f)(2)	If dependent coverage is selected by the policyholder, the policy form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to Domestic Relations Law § 115-c within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. *Note: In the case of individual or two-person coverage, the insurer must permit the insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of birth to make coverage effective from the moment of birth.*	
Spouse	§ 4235(f) Circular Letter No. 27 (2008)	If dependent coverage is selected by the policyholder, the policy provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes the recognition of marriages between same-sex partners legally performed in New York and other jurisdictions.	
Unmarried Disabled Children	§ 4235(f)(1)(A)(ii)	If dependent coverage is selected by the policyholder, the policy provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate.	

		Note: Such coverage shall not terminate while the policy remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.	
Unmarried Students on Medical Leave of Absence	§ 3237	If the policy provides coverage for dependent children who are full-time students to a higher age than other dependent children, then coverage shall continue when such dependent takes a medical leave of absence from school due to illness for a period of 12 months from the last day of attendance at school, provided, however, that coverage of a dependent student is not required beyond the age at which coverage would otherwise terminate. To qualify for such coverage, the insurer may require that the medical necessity of the leave be certified to by the student's attending physician who is licensed to practice in the state of New York.	
DISABILITY INCOME INSURANCE STANDARD PROVISIONS			
Accident Benefits	11 NYCRR 52.9 11 NYCRR 52.18(b)(1), (2), (3), (7)	If the form contains benefits due to an accident in addition to disability income: • Accident benefits are NOT predicated upon loss occurring through violent and external means. Accidental means shall be interpreted in New York in accordance with applicable New York case law. Under this provision, the policy may not exclude benefits relating to a loss associated with terrorism. • Benefits for a specific injury due to accident are NOT payable in lieu of disability benefits unless the specific benefit exceeds the disability benefit. Accident benefits are payable if the loss occurs a minimum of 90 days from the date of the accident, irrespective of total disability. *Note: Benefits for follow-up care that are based upon the occurrence of a loss (e.g., rehabilitation benefits) should provide the insured with adequate time to access the benefit. For instance, to require treatment under a rehabilitation benefit to be completed within 90 days of the covered accident may be illusory given the timing associated with entering a rehabilitation program following an accident.* • If accident benefits are conditioned upon hospital confinement, it shall be considered hospital, surgical or medical benefits for purpose of Insurance Law § 3221(e) and any relevant regulations.	
Definition of Disability	11 NYCRR 52.8	The policy form should clearly state the definition of a disability. For example, a policy form may define disability as when an insured is unable to perform his/her "own occupation" or "any occupation."	
Disability Benefit Amount	11 NYCRR 52.1(c) 11 NYCRR 52.8	The policy form provides for a benefit to replace the insured's income due to the insured's inability to work because of a disability. The benefit may replace up to 80% of the insured's income. If the disability benefit exceeds 80% of the insured's pre-disability income, a justification should be submitted with the filing, explaining why the benefit is necessary.	
Occupational/Work-Related Disabilities	11 NYCRR 52.16(c) 11 NYCRR 52.16(c)(8)	The policy form must not distinguish between occupational (work-related or "on-the-job") or non-occupational disabilities, or limit, reduce or exclude coverage for either occupational or non-occupational disabilities. To cover only occupational or non-occupational disabilities excludes other types of disabilities in violation of 11 NYCRR 52.16(c).	

		Note: An exclusion is available for benefits provided under any state or federal workers' compensation law. § 52.16(c)(8).	
OTHER INCIDENTAL BENEFITS IN IN A DISABILITY INCOME INSURANCE POLICY	§ 3201(c)(3) § 3217(b)(5) 11 NYCRR 52.1(c) Circular Letter No. 18 (2017)	If this policy form provides benefits in addition or incidental to those under 11 NYCRR 52.8, any such benefit should have a nexus to disability income insurance. All benefits must be of real economic value and may not be designed to play upon one's fears of particular diseases. Disability income insurance policies which are unduly complex or unduly limited do not meaningfully expand consumer choice, but instead serve to confuse and make intelligent choice more difficult. Those coverages which are of no substantial economic benefit or are contrary to the health care needs of the public or contain provisions which serve only to confuse or obfuscate are prohibited under 11 NYCRR 52.1(c). Benefits must be reasonable in relation to the premium charged. *Note: The following are several examples of benefits that have been approved in the past. This list is not meant to be exhaustive.*	
Cost of Living Adjustment (COLA or Inflation Benefit)		Provides an increase in the monthly benefit after the insured has been continuously disabled for a specified waiting period.	
Contribution Benefit or Waiver of Health Insurance Premium Benefit		This benefit is paid as an employee/insured's contribution toward insurance benefits while the insured cannot work. Benefits may not be payable to the employer pursuant to Insurance Law § 4235(e).	
Education Benefit (Child Education, Spousal Retraining)		This benefit defrays the cost of any education for a child or spouse while the insured cannot work.	
Family Care Benefit (Child Care, Parental Care)		This benefit pays for the dependent care of a child or family member while the insured's disability prevents him/her from caring for, or paying for care for, the individual.	
Family Extension Benefit	11 NYCRR 52.18(e)	This benefit provides for the continuation of coverage for the insured's dependents following the death of the insured when the insured has family coverage.	
Home Alteration/Vehicle Modification Benefit		This benefit provides an additional benefit to the insured to be used to modify the insured's home or vehicle to allow the insured to use the home or vehicle despite their disability. This benefit is approvable if the following requirements are included: • A physician certifies the benefit is needed to accommodate a physical disability; • The alteration/modification is made by someone experienced in such adaptations; • The alteration/modification is in compliance with applicable laws or requirements for the approval by the appropriate government authorities; and • The alteration/modification expenses do not exceed the usual level of charges for similar alterations/modifications in the locality where the expense is incurred.	
Rehabilitation Benefits	11 NYCRR 52.1(c)	If the policy form contains a rehabilitation benefit, the benefit must clearly explain whether participation by the insured in the rehabilitation program is voluntary or mandatory. The purpose of the benefit is to aid the insured in returning to work. To the extent the rehabilitation benefit is not specifically described in the policy form, the insured and insurer must agree in writing to the nature of the benefits and the amount payable.	
Retirement Benefit (401(k), Pension Contribution		This benefit is paid as an employee/insured's contribution toward retirement benefits while the insured cannot work. Benefits may not be payable to the employer pursuant to Insurance Law § 4235(e).	
Value-added services/non-insurance services	§ 1113(a)(29) § 4224(c) 11 NYCRR 52.1(c) 11 NYCRR 52.18(a)(8)	Value-added services, or non-insurance services, are additional benefits and services offered in connection with the sale of insurance that add value beyond the standard approvable benefits typically associated with disability income insurance. Any value-added service submitted for approval is subject to the following minimum requirements:	

	Circular Letter No. 9 (2009) Circular Letter No. 18 (2017)	• Any goods or services offered in the policy or contract shall have a rational nexus to the insurance coverage provided under the policy or contract and shall be necessarily or properly incidental to the insurer's insurance business. Circular Letter No. 9 (2009), Circular Letter No. 18 (2017) • A value-added service shall not run afoul of any rebating and inducement prohibitions and shall be specified in the policy or contract unless the fair market value of the service is $25 or less. The $25 limitation applies to all such valuable consideration in total provided during any policy term. § 4224(c), Circular Letter No. 9 (2009) • The value-added service shall not violate any Insurance Law or regulation (e.g., Insurance Law § 4235(e) – the benefit shall be payable to the employee or insured, and not to the employer or association). • The value-added service shall provide the insured with real economic value pursuant to 11 NYCRR 52.1(c). • The value-added service shall not terminate at will. Unilateral modifications by an insurer to an existing policy shall be made with at least 30 days' prior written notice to the policyholder. § 52.18(a)(8). • If the value-added service is administered by a third-party administrator, or any other outside vendor, the policy form shall not contain language that purports to absolve the insurer of liability to the insured for the vendor's actions. *Note: Examples of value-added services that have not been approved are legal and financial assistance services. Legal services is a type of insurance offered pursuant to Insurance Law § 1113(a)(29). See Circular Letter No. 9 (2009).*	
Waiver of Premium Benefit		This benefit waives future premiums due under the policy during a period of disability resulting from an illness or injury.	
MANDATORY STANDARD PROVISIONS		*Note: These provisions MUST be included in each policy. The provision must be no less favorable to the insured than the statutory provision.*	
Arbitration	§ 3221(a)(14)	The policy form cannot provide for mandatory arbitration. An arbitration provision which makes arbitration mandatory conflicts with Insurance Law § 3221(a)(14) since it precludes an insured from bringing an action at law or equity.	
Certificate	§ 3221(a)(6)	The insurer shall issue either to the employer or person in whose name the policy is issued, for delivery to each member of the insured group, a certificate setting forth in summary form a statement of the essential features of the insurance coverage.	
Changes	§ 3221(a)(2)	The policy form must provide that no agent has the authority to change the policy or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy, or by amendment to the policy signed by the policyholder and insurer.	
Claim Forms	§ 3221(a)(10)	The policy form must provide that the insurer will furnish the insured or the policyholder such forms as are usually furnished for filing proof of loss. If such forms are not furnished before the expiration of fifteen days after the insurer receives notice of the claim, the insured shall be deemed to have complied with the proof of loss requirements upon submitting within the time fixed written proof covering the occurrence, character and extent of the loss for which the claim is made.	
Entire Contract	§ 3204	The policy form, including any endorsements or attached papers (if any), constitutes the entire contract of insurance. No change in the policy will be valid unless it is approved by an executive officer of the insurer and the approval is endorsed on or attached to the policy. No agent or broker has the authority to change the policy or waive any of its provisions.	

		Incorporation by reference is not permitted.	
Indemnity for Loss of Life	§ 3221(a)(13) § 4235(e)	The policy form must provide that indemnity for loss of life is payable in accordance with Insurance Law § 4235(e). According to Insurance Law § 4235(e), the benefits payable under the policy shall be payable to the employee or other insured member of the group or to some beneficiary or beneficiaries designated by him, other than the employer or the association or any officer thereof. If a beneficiary is not designated, then the benefits shall be payable to the estate of the employee or member. The insurer, at its option, may pay such insurance to any one or more of the following surviving relatives of the employee or member: wife, husband, mother, father, child or children, brothers or sisters. Payments so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.	
Legal Action	§ 3221(a)(14)	The policy form must provide that no action in law or equity shall be brought to recover on the policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought after the expiration of two years following the time such proof of loss is required by the policy.	
Misstatement	§ 3221(a)(1)	The policy form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	
Notice of Claim	§ 3221(a)(8)	The policy form must provide that the insured has a minimum of 20 days to provide the insurer with written notice of claim. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	
Payment of Claims	§ 3221(a)(12)	The policy form must provide that benefits payable under the policy other than for benefits for loss of time will be payable not more than 60 days after receipt of proof of loss.	
Physical Examinations and Autopsy	§ 3221(a)(11)	The insurer shall have the right and opportunity to examine the insured making a claim as reasonably required during the pendency of the claim and the right and opportunity to conduct an autopsy in the case of death unless prohibited by law.	
Premium Payment and Grace Period	§ 3221(a)(4)	The policy form includes a statement that all premiums due under the policy shall be remitted by the employer or employers of the persons insured or by some other designated person acting on behalf of the association or group insured, to the insurer on or before the due date thereof, with such grace period as may be specified therein.	
Proof of Loss	§ 3221(a)(9)	The policy form provides that in the case of a claim for loss of time for disability, the insured has a minimum of 30 days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability shall be furnished to the insurer at such intervals that the insurer may reasonably require. In the case of any other claim, the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	
Renewal	§ 3221(a)(5) 11 NYCRR 52.18(c)	The policy form must specify the conditions under which the insurer may refuse to renew the policy.	
OPTIONAL STANDARD PROVISIONS		*If optional standard provisions are included in the policy, they must comply with the following.*	
Elimination Period	§ 3201(c)(3) Supplement No. 1 to Circular Letter No. 14 (2007)	Elimination periods of no longer than 180 days are viewed as reasonable. Elimination periods of any longer duration may work a hardship on a disabled insured. Insurers seeking approval of elimination periods that exceed 180 days should explain why the elimination period is necessary and how they will mitigate the hardship on the disabled insured.	

		Elimination periods and pre-existing condition waiting periods in group disability polices should run concurrently rather than consecutively. To treat them as running consecutively would create the possibility of extremely long periods of time during which a disabled insured would receive no benefits. All elimination periods should be construed to run from the first date of the disability, rather than upon expiration of the pre-existing condition waiting period. Payment of benefits therefore should begin upon expiration of the elimination period, subject to the pre-existing condition waiting period. If the pre-existing condition limitation has been satisfied, then payment of benefits should begin upon expiration of the elimination period. In cases where the elimination period has been satisfied and the pre-existing condition limitation has not been satisfied, payment of benefits should begin on the first day of the month following the expiration of the pre-existing condition limitation.	
Nonduplication of Coverage and Coordination of Benefits Provisions (Offsets)	11 NYCRR 52.18(d) 11 NYCRR 52.16(c)(8)	The policy form may contain a coordination of benefits provision. Coordination of benefits provisions in group contracts may apply to service type plans, prepaid group practice plans, group and blanket insurance, self-insured or noninsured plans, franchise plans, group salary continuance programs, State or Federal programs except Medicaid and mandatory no-fault automobile insurance benefits. The policy form may offset or coordinate coverage only to the extent benefits are provided (i.e., paid) under Medicare or other governmental programs (except Medicaid) or any state or federal workers' compensation, employers' liability or occupational disease law. Life, annuity, or pension benefits under a plan of the same or a related employer (meaning any individual, partnership or corporation under common control) may be offset against disability income benefits, subject to the following: • Early retirement benefits may be offset only if such early retirement is elected by the employee or does not reduce the amount of his accrued annuity or pension benefits then funded; • Disability income benefits under a life insurance plan may be offset only if payment of such benefits does not reduce the amount of the employee's life insurance or if an employee may elect not to apply for such benefits even though disabled. The policy for may not offset the payment of benefits thereunder by benefits provided under volunteer firefighter enhanced cancer insurance.	
Offsets for Estimated Benefits	11 NYCRR 52.16(c)(8)	The policy form may contain an offset provision for estimated benefits payable under Social Security Disability Income, State or Federal workers' compensation, employers' liability or occupational disease law, subject to the following requirements: • The insurer shall only offset policy benefits at the insured's request; • The insured shall have the right to opt out of their request to offset estimated benefits at any time; • If the insured opts out of their request to offset their policy benefits using estimated benefits, the insurer shall adjust policy benefit payments accordingly and immediately refund any underpayment of benefits to which the insured is entitled, in a lump sum; and • The insurer shall only estimate benefits payable under the Social Security Act when it has a reasonable basis upon which to believe that the insured will qualify for such benefits under standards set forth by the Social Security Administration. *Note: The policy form must describe the procedures regarding offsets using estimated benefits, including each of the above requirements.*	

Pre-existing Condition Limitation	§ 3234 (as added by L.1993, c. 650) 11 NYCRR 52.18(a)(5) Circular Letter No. 14 (2007) Supplement No. 1 to Circular Letter No. 14 (2007)	The policy form may include a pre-existing condition exclusion that: • Defines a pre-existing condition as one which relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date; and • Excludes pre-existing conditions for a period of up to 12 months from the enrollment date. A pre-existing condition exclusion establishes a waiting period, rather than a total bar, for coverage of disabilities due to a pre-existing condition that begin within 12 months of an insured's effective date of coverage. The policy form shall credit the time the insured was previously covered under a previous group or blanket disability insurance plan or policy or employer-provided disability benefit arrangement, if the previous coverage was continuous to a date not more than 60 days prior to the effective date of the new coverage. The credit shall apply to the extent that the previous coverage or level of benefits was substantially similar to the new coverage or level of benefits. If the policy is delivered or issued to a group which includes persons aged 65 or older, such policy shall not contain any provision which excludes, limits or reduces coverage for a loss due to a pre-existing condition for those aged 65 or older for a period greater than six months following the effective date of coverage.	
Subrogation	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a)	Any subrogation provision must comply with the General Obligations Law that affects an insurer's reimbursement rights. When an insured settles a claim, whether in litigation or otherwise, against one or more other persons for personal injuries, medical, dental, or podiatric malpractice, or wrongful death, it shall be conclusively presumed that the settlement does not include any compensation for the cost of health care services, loss of earnings or other economic loss to the extent those losses or expenses have been or are obligated to be paid or reimbursed by an insurer. By entering into any such settlement, an insured shall not be deemed to have taken an action in derogation of any right of any insurer that paid or is obligated to pay those losses or expenses; nor shall an insured's entry into such settlement constitute a violation of any contract between the insured and such insurer. No insured entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by an insurer and an insurer shall have no lien or right of subrogation or reimbursement against any such settling person or any other party to such a settlement, with respect to those losses or expenses that have been or are obligated to be paid or reimbursed by said insurer.	
Unilateral Modification	11 NYCRR 52.18(a)(8)	Unilateral modifications by an insurer to an existing policy must be made with at least 30 days' prior written notice to the policyholder. When a policyholder is contractually required to provide prior written notice to terminate coverage, an insurer must provide notice of a unilateral modification at least 14 days prior to the date by which the policyholder is required to provide notice to terminate coverage.	
TERMINATION PROVISIONS			
Extension of Benefits	11 NYCRR 52.18(b)(4)	Upon termination of insurance, whether due to termination of employment, termination of eligibility or termination of the policy, an extension of benefits shall be provided during a period of	

		total disability for hospital confinements commencing or surgery performed during the next 31 days for the injury, sickness or pregnancy causing the total disability.	
Notice of Termination	11 NYCRR 52.18(c)	Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days' prior written notice.	
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		*Only the following exclusions or limitations are permissible. Not all exclusions must be included, but if an exclusion or limitation is included the language from the statute or regulation must be used.*	
Alcoholism and Drug Addiction	11 NYCRR 52.16(c)(2)	The policy form may exclude coverage for alcoholism or drug addiction.	
Aviation	11 NYCRR 52.16(c)(4)(iii)	The policy form may exclude coverage for illness, accident, treatment, or medical condition arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	
Chiropractic Care	11 NYCRR 52.16(c)(7)	The policy form may exclude care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.	
Convalescent, Custodial Care and Transportation	11 NYCRR 52.16(c)(11) 11 NYCRR 52.25(a)(1)	The policy form may exclude coverage for rest cures, custodial care, and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities.	
Cosmetic Surgery	11 NYCRR 52.16(c)(5)	The policy form may exclude coverage for cosmetic surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. *Note: All exclusions for cosmetic surgery must be based on medical necessity, with the insured receiving all utilization review and external appeal rights under Article 49.*	
Coverage Outside of the United States, Canada or Mexico	11 NYCRR 52.16(c)(12)	The policy form may exclude for coverage while the insured is outside of the United States, its possessions, Canada or Mexico.	
Dental Care	11 NYCRR 52.16(c)(9)	The policy form may exclude coverage of dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and for dental care or treatment necessary due to congenital disease or anomaly.	
Extra-hazardous Activities	11 NYCRR 52.16(e) 11 NYCRR 52.2(i)	The policy form may exclude coverage for extra-hazardous activities in accordance with 11 NYCRR 52.16(e). The insurer must seek a signed waiver of coverage from the prospective insured or, in the alternative, place the extra-hazardous activity exclusionary language on the cover page of the policy and certificate. For additional information, see the "Extra-hazardous Activities" section under "Application Forms." *Note: The Department has determined that the following activities are not "extra-hazardous" as defined by 11 NYCRR 52.2(i) and may not be excluded under the policy: base jumping, bungee jumping, caving, parasailing, parkour, mountain or rock climbing, or scuba diving. This list is not meant to be exhaustive.*	
Eyeglasses, Hearing Aids and Exams	11 NYCRR 52.16(c)(10)	The policy form may exclude coverage for eyeglasses, hearing aids and examination for the prescription or fitting thereof.	
Felony Participation, Riot, or Insurrection	§ 3216(d)(2)(J)	The policy form may exclude coverage for any illness, accident, treatment or medical condition due to the insured's participation in a felony, riot or insurrection.	

	11 NYCRR 52.16(c)(4)(i)		
Foot Care	11 NYCRR 52.16(c)(6)	The policy form may exclude coverage for foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.	
Government Hospital	11 NYCRR 52.16(c)(8)	The policy form may exclude coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise provided by law.	
Illegal Occupation	§ 3221(c) § 3216(d)(2)(J)	The policy form may exclude losses to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.	
Immediate Family	11 NYCRR 52.16(c)(8)	The policy form may exclude coverage for services performed by a member of the insured's immediate family. Immediate family has the same meaning as defined in 42 CFR § 411.351: husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.	
Intoxicants and Narcotics	§ 3221(c) § 3216(d)(2)(K)	The policy form may exclude coverage for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.	
Medicare, Other Governmental Programs and Workers' Compensation	11 NYCRR 52.16(c)(8) OGC Opinion 06-12-09	The policy form may exclude coverage for benefits provided under Medicare or other governmental programs (except Medicaid) or any state or federal workers' compensation, employers' liability or occupational disease law, unless where otherwise provided in State or Federal statute.	
Mental Health or Substance Use Disorders	11 NYCRR 52.16(c)(2)	The policy form may exclude coverage of mental health or substance use disorders. If the policy provides coverage for mental health or substance use disorders, coverage should be provided for at least 12 months and should be provided for any mental health or substance use disorder.	
Military Service	11 NYCRR 52.16(c)(4)(i)	The policy may exclude coverage for a disability due to service in the armed forces or auxiliary units. *Note: If the insurer excludes coverage for a disability due to service in the armed forces, then the insurer should offer to suspend the insured's coverage during a period of active duty of up to four years.*	
No-Fault Automobile Insurance	11 NYCRR 52.16(c)(8)	The policy form may exclude coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	
Pregnancy	11 NYCRR 52.16(c)(3) 11 NYCRR 52.2(e)	The policy form may exclude coverage for pregnancy including complications of pregnancy. See the "Complications of Pregnancy" definition under the "Definitions" section.	
Services Separately Billed by Hospital Employees	11 NYCRR 52.16(c)(8)	The policy form may exclude coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	
Services For Which No Charge Is Normally Made	11 NYCRR 52.16(c)(8)	The policy form may exclude coverage for services for which no charge is normally made.	
Suicide, Attempted Suicide, Intentionally Self-Inflicted Injury	11 NYCRR 52.16(c)(4)(ii)	The policy form may exclude coverage for illness, accident, treatment or medical condition arising out of suicide, attempted suicide or intentionally self-inflicted injury. *Note: No distinction is made for whether the insured is sane or insane*.	

War or Act of War	11 NYCRR 52.16(c)(4)(i)	The policy form may exclude coverage for illness, accident, treatment or medical condition arising out of war or act of war (whether declared or undeclared) *Note: Exclusions for terrorism are not permitted.*	
ACTUARIAL SECTION FOR NEW PRODUCT RATE REQUIREMENTS		*Complete this section for all forms filings except those filings where a rate filing is unnecessary because: (**select one**)* ☐ *The submission contains only application forms, disclosure statements, and/or advertising; OR* ☐ *The submission is an out-of-state filing pursuant to Section 3201(b)(2); OR* ☐ *The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as* appropriate. (For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below instead.)	Form & Page Number
ACTUARIAL MEMORANDUM	11 NYCRR 52.40(a)(1)	The actuary preparing the filing meets the following actuarial qualifications: a. Member of the Society of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	11 NYCRR 52.40(e) 11 NYCRR 52.40(f)	a. Development of manual rates including actuarial assumptions used and justification thereof. b. Provide rating methodology, including experience rating formula, if applicable. c. Provide all elements of the experience rating formula, such as claims run-off, credibility and trend factors. d. Provide actuarial justification of all assumptions used. e. Non-claim expense components as a percentage of gross premium. f. Expected loss ratio(s).	
Loss Ratios	11 NYCRR 52.45(f)	Expected loss ratio(s) with actuarial justification.	
Actuarial Certification	11 NYCRR 52.40(a)(1)	g. The filing is in compliance with all applicable laws and regulations of the State of New York. h. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans" as adopted by the Actuarial Standards Board. i. The expected loss ratio meets the minimum requirements of the State of New York. j. The benefits are reasonable in relation to the premiums charged. k. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification		The expected loss ratio is: _____ %	
RATE MANUAL	11 NYCRR 52.40(e)	a. Rate manual pages, unless schedules of rates or formulas applicable to the forms have been previously filed. In such case the rates shall be identified by reference to the specific page number(s) of the manual that apply. b. Table of Contents. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Outline of benefits, coverages, limitations, exclusions, and issue limits. f. Description of rating classes and premium discounts. g. Examples of rate calculations. h. Commission schedule(s).	

		i. Underwriting guidelines and/or underwriting manual. j. Expected loss ratio(s).	
ACTUARIAL SECTION FOR EXISTING PRODUCT RATE REQUIREMENTS		*Complete this section for all filings of changes in rates (e.g., rate increases/decreases or changes in rate calculation rules or procedures), commissions, or underwriting to existing products.* *(For new products, do NOT complete this section – complete the New Products-Rate Requirements section above.)*	Form & Page Number
ACTUARIAL MEMORANDUM	11 NYCRR 52.40(a)(1)	The actuary preparing the filing meets the following actuarial qualifications: a. Member of the Society of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	11 NYCRR 52.40(e) 11 NYCRR 52.40(f) 11 NYCRR 52.45(f)	a. Description of proposed revision in premiums, commissions, underwriting rules/risk classification, or benefits. b. Provide New York and nationwide claims experience since inception respectively, including: (i) Earned premium (ii) Paid and incurred claims (iii) Incurred loss ratios c. History of previous New York rate revisions. d. Average premium impact of the revision. e. Actuarial justification for the proposed revision. f. Demonstration that applicable minimum loss ratio will be met. g. Specific reference to new rate manual pages to be added or pages to be deleted or replaced. h. Expected loss ratio(s) after the proposed changes.	
Actuarial Certification	11 NYCRR 52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans". c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification		The expected loss ratio is: %.	
REVISED RATE MANUAL PAGES	11 NYCRR 52.40(e) 11 NYCRR 52.40(j)	a. Revised rate manual page or pages to be added. b. Insurer name on each consecutively numbered rate page.	