NEW YORK STATE OF OPPORTUNITY. Department of Financial Services

# Accelerated Payment of Death Benefit Outline

(Last updated February 19, 2021)

**Product Outline: Accelerated Payment of Death Benefit (Last updated February 19, 2021).**

This outline is current as of February 19, 2021. 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.

I) Scope

A. This product outline applies to accelerated death benefit provisions provided by an individual or group life insurance policy or rider or fraternal benefit certificate. This outline replaces the Accelerated Payment of the Death Benefit Product Outline dated April 20, 2016.

B. An accelerated death benefit must comply with Insurance Law §§ 3201(c)(11)(A) and 3230 as well as Regulation 143. Regulations pertaining to the provision of long-term care benefits in accident and health products are not applicable to the acceleration of death benefits in a life insurance policy.

C. This outline focuses primarily on policy form related requirements. However, Regulation 143 should be reviewed for additional requirements related to areas such as: sales, claims, marketing, preliminary information, illustration, the insurer's responsibility to ensure that section 1113(a)(1)(C) and (D) benefits, on a standalone basis, meet requirements for federal tax qualification, etc.

II) Filing Process

II.A) General Information

A.1) Prior Approval Requirement

Section 3201(b)(1) provides that no policy form may 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).

A.2) Discretionary Authority for Disapproval.

Sections 3201(c)(1) and (2) permit the Superintendent to disapprove any policy form that contains provisions that are misleading, unfair, unjust, or inequitable or if its issuance would be prejudicial to the interests of policyholders or members.

A.3) No filing fee required.

A.4) Filings Must Be Submitted Through State Electronic Rate and Forms Filing system ("SERFF")

(a) Effective May 25, 2020, 11 NYCRR 6 (Insurance Regulation 195) will require that policy form, rate, and compensation filings must be submitted through SERFF. As of May 25, 2020, the Department will no longer accept paper filings or filings made in any manner other than SERFF, except where an exemption has been granted for a specific submission pursuant to section 6.3 of Regulation 195.

(b) For general guidelines regarding SERFF submissions, please see the guidance for SERFF filings available on the Department's website at https://www.dfs.ny.gov/apps_and_licensing/life_insurers/general_serff_guidelines_for_form_filings.

(c) Exemption from SERFF Submission Requirement

An insurer that is required to make a submission using SERFF pursuant to Regulation 195 may apply for an exemption from the requirement that a particular filing be made electronically by submitting a written request that complies with the requirements set forth in Section 6.3 of Regulation 195. Guidance on requesting an exemption may be found on the Department's website at: https://www.dfs.ny.gov/apps_and_licensing/life_insurers/reg195_filing_guidance.

II.B) Types of Filing

B.1) Prior Approval

Policy forms submitted under Section 3201(b)(1) of the Insurance Law are subject to the submission rules noted herein, especially Circular Letter Nos. 6 (1963) and 14 (1997).

B.2) Alternative Approval Procedure ("Deemer")

(a) 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.

(b) Circular Letter No. 2 (1998) provides that the certification of compliance should make reference to any law or regulation that specifically applies or is unique to the type of contract form submitted. An alternative would be to submit a certification of compliance with the applicable laws and

regulations cited in the product outline. A statement that the filing is in compliance with all applicable laws and regulations is not acceptable

B.3) Prior Approval With Certification Procedure

(a) 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 altered or otherwise modified the language of the certification will not be accepted.

(b) The original signed 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. When a certification pertains to a large number of forms, the list may begin in the body of the certification and continue in list form on the second page.

(c) The SERFF Filing Description must comply with applicable circular letter and Outline guidance.

(d) 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.

(e) The Circular Letter No. 6 (2004) process is not permitted for benefits accelerated under Sections 1113(a)(1)(E) and 1113(a)(1)(F) without prior permission of the Department

B.4) 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 SERFF Filing Description 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 (e.g: the Spanish version of form Term-123 could be Term-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. The certification must state that the underlying English language policy form achieves a minimum Flesch score of 45 in accordance with Section 3102(c)(1)(D). 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.

B.5) Filings for Out-Of-State Delivery Only

The Department no longer requires the filing of policy forms to be delivered out of state (except unallocated group annuity contracts or funding agreements). Section 3201(b)(2). Domestic insurers are required to annually file a list of policy forms issued by the insurer or fraternal benefit society for delivery out of state. Section 3201(c)(6)(b).

II.C) Preparation of Forms

C.1) Duplicates

Filings, except for SERFF filings, must be made in duplicate. Section I.E.7 of Circular Letter No. 6 (1963).

C.2) Form Numbers

Form numbers must appear in the lower left corner of the cover page of the form. Section I.D of Circular Letter No. 6 (1963). The lower left corner of the subsequent pages of the form should either contain the same form number as the cover page or be left blank. The subsequent pages should not contain form numbers that differ from the form number on the cover page.

C.3) Hypothetical Data

All blank spaces for policy forms, except applications, must be filled in with hypothetical data. Section I.E.1 of Circular Letter No. 6 (1963).

C.4) Application

(a) The application to be used to obtain an accelerated death benefit policy or rider policy form must be an approved form. When submitting a policy form to which a copy of the application will be attached when issued, the form and file number for the previously approved application must be supplied. If the application has not been approved, the application form must be submitted with the policy forms for approval. If the application is already pending approval, please provide the Department's file number. Section I.E.4 of Circular Letter No. 6 (1963).

(b) The application must comply with Section 3230(a) of the Insurance Law and Section 41.4(c) of Regulation 143 (See Section V of this outline). The Company must retain information in its records concerning which approved application is being used or has been used with the accelerated death benefit policy or rider and the type of underwriting utilized. Such information must be available upon Department request. See Regulation 152.

C.5) Final Format

Policy forms submitted for formal approval should be submitted in the form intended for actual issue. Section I.F.1 of Circular Letter No. 6 (1963). Revisions to font style, paper, weight and ink color are permitted provided that the forms continue to comply with all applicable laws, including but not limited to Sections 3102 and 3201(c)(4). A company may not reserve the right to make additional revisions outside of those specifically listed above.

C.6) Submissions Made on Behalf of the Company

If the filing is made on behalf of the insurer by another party, the "SERFF Filing Company" field must identify the name of the insurer on whose behalf the filing is being made and a letter authorizing the third party to act on behalf of the company must be provided. The letter must be:

(a) on company letterhead or include the company name in the subject line of the letter;

(b) specifically addressed to the New York State Department of Financial Services;

(c) properly executed by an authorized officer of the insurer;

(d) dated; and

(e) either

(i) specific to the file submitted for approval by including form number(s); or

(ii) generally applicable to all policy forms filed on behalf of the insurer as long as a copy of such authorization is included in each submission.

It is the insurer's responsibility to ensure that their authorizations are accurate and reflect their current relationship with the third party filer.

C.7) Other Applicable Requirements

The policy containing an accelerated death benefit, or the policy to which an accelerated death benefit rider is attached, must comply with all filing requirements relevant to the product. See the applicable product outline.

C.8) Circular Letter No. 14 (1997)

Filings that are incomplete or do not comply with laws and regulations will be returned. See Circular Letter No. 14 (1997). Note that a product that does not comply with a specific product outline requirement or which is considered to be substantively non-compliant will be a factor in determining whether a file will be closed.

C.9) Circular Letter No. 8 (1999)

For SERFF submissions, the Form Schedule will replace the "RE" requirement of Circular Letter No. 8 (1999). See Special Forms Schedule Handling of the General SERFF Guidelines for Forms Filings.

C.10 Numbering Variable Material

If variable material within the policy form is numbered to identify the corresponding entry in the memorandum of variability (Department recommends this as a best practice), this numbered version of the policy form should be attached as the policy form under the Form Schedule in SERFF. The company does not need to submit a separate "clean" copy of the application with the numbers removed. If a company elects to include a "clean" version in the submission, it should be included under the Supporting Documentation tab in SERFF.

II.D) SERFF Filing Description/Requested Filing Mode

All relevant information regarding the submission, including the specified information set forth below, must be included in the SERFF Filing Description.

Note: References in this outline to Filing Description requirements are also applicable to submission letters for non-SERFF filings made pursuant to an exemption, unless otherwise noted. For non-SERFF filings, any information that would ordinarily be included in the Filing Description must be included in a separate signed cover letter.

D.1) Filing Basis

The first sentence of the SERFF Filing Description should identify the type of filing, such as prior approval, Circular Letter No. 6 (2004) certified filing, etc., (see Filing Basis section of the General SERFF Guidelines for Form Filings) and must be consistent with the Requested Filing Mode in SERFF.

D.2) Compliance with Section I.G of Circular Letter No. 6 (1963)

(a) Identify form number of each form submitted.

(b) Indicate whether (1) the forms are replacing a previously approved form (provide the form number and date of approval); (2) the form will be issued in addition to other similar forms and/or benefits (provide form numbers and dates of approval); or (3) the form is a new form unlike any previously approved form.

(c) If the form is other than a policy or contract (e.g. a rider, endorsement or insert page), give the form number of the policy or contract form or forms with which it will be used, or, if for more general use, describe the type or group of such forms as well as whether the pending forms will be used with new and/or previously issued/delivered policies.

(d) If there are similar forms (e.g. other accelerated death benefit riders) not being replaced, identify those forms and indicate why they are not being replaced.

(e) Substitution

If an insurer wishes to replace a very recently approved policy form because of an error found after approval, the insurer may request to make a substitution in the original file. A substitution is available if the approved policy form has not been issued and the insurer is only fixing a minor error. To request a substitution, the insurer should submit a Note to Reviewer in SERFF in the original file in which the form was approved. The request should confirm that the form has not been issued and identify the correction the insurer wishes to make. If the reviewer determines that a substitution is appropriate, the reviewer will reopen the SERFF file and the insurer will need to "amend" the SERFF file to replace the previously approved policy form with the corrected form in the SERFF Form Schedule. The insurer may, under these circumstances, use the same form number on the corrected form.

If a substitution in the original file is not available (e.g., policy form was issued, significant revisions being made, etc.) or the insurer does not wish to do a substitution, then the insurer would need to submit the new version of the policy form, with a new form number, in a new filing.

Note: The substitution process is not available for policy forms approved under the Circular Letter No. 6 (2004) procedure. Any change to a form previously approved under the Circular Letter No. 6 (2004) procedure requires a separate new filing and new form number.

(f) For paper submissions:

(i) Submit in duplicate. Section I.E.7 of Circular Letter No. 6 (1963).

(ii) The submission letter must be signed by a representative of the insurer authorized to submit forms for filing or approval for the insurer.

(g) For E Triggers, the policy form filing should specify the manner in which the insurer will base the expectation on an objective analysis and ensure that the E Trigger will not be subject to abuse.

D.3) Explanation of Unique Features and Markets

(a) Identify any special markets where this form will be used, including, but not limited to, employer-employee payroll deduction, senior citizen, juvenile, military, mail-order, COLI, BOLI, pre-need, and private placements.

(b) Fully explain any feature that has not been previously approved by the Department for the insurer or that is new to the marketplace in New York.

D.4) Noncompliance Explanation

If the form does not comply with a specific provision of this Outline, the SERFF Filing Description, must identify the provision and provide a complete explanation of the insurer'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.

D.5) Resubmissions

If the form has been previously submitted to the Department and the file was closed, any resubmission of the form to the Department must reference the file number of the previously closed file and address all outstanding issues in the new SERFF Filing Description. The submission must be complete in and of itself and may not incorporate previously submitted material by reference.

D.6) Acceleration Mechanisms

The submission letter should identify the approach utilized for acceleration (e.g. discount approach, lien approach with interest accrual).

D.7) Triggers

(a) Insurance Law §1113(a)(1)(A), (B), (C), (D), (E) and (F) provide six "triggers" for accelerating death benefits under a life insurance policy or rider. The submission letter must identify which letter item(s) in Section 1113(a)(1) pertain to the submitted policy or rider (see Section III of this outline). In addition, the rider itself must be clear as to which Section(s) of 1113(a)(1) pertain.

(b) For benefits accelerated pursuant to Section 1113(a)(1)(C) or (D), the submission letter must state whether the policy is intended to be a qualified long-term insurance care contract for federal tax purposes.

(c) For benefits accelerated pursuant to Section 1113(a)(1)(C) or (D) the submission letter must also identify whether the payments are to be made on a per diem or cost incurred basis.

(d) Any life insurance policy, certificate, or rider that provides accelerated death benefits pursuant to the B, C, D, E, or F Trigger must also provide for the accelerated payment of death benefits based on the A Trigger (occurrence of a diagnosis of terminal illness where life expectancy will not exceed 12 months or a shorter period as specified in the policy or rider). Section 3201(c)(11)(A), Section 41.6(a)(3) of Regulation 143. Benefits pursuant to the A Trigger may be provided in a separate form. The submission should explain how this will be accomplished.

D.8) Coordination of Benefits

For benefits accelerated pursuant to Section 1113(a)(1)(C) or (D), the submission letter must state whether the insurer elects to coordinate benefits. See section V.B of this outline.

II.E) Attachments

E.1) Readability Certification

Provide a Flesch score certification signed by an officer of the insurer in accordance with Section 3102. The Flesch score must be at least 45. Please refer to the Department's February 18, 1982 letter, available on the Department's website, for a sample certification at:

https://www.dfs.ny.gov/apps_and_licensing/life_insurers/guidance_readability_Feb_1982Please note that the Memorandum of Variable Material for each form must be listed separately in the Flesch score certification. The certification should be attached under Supporting Documentation in SERFF.

E.2) Variable Material

The submission must include a separate detailed memorandum of variability for any variable material. The memorandum of variability is subject to approval, must comply with the filing guidance on the Department's website, and should be submitted under the Form Schedule in SERFF.

E.3) Nonforfeiture Memorandum/Certification.

Include the nonforfeiture memorandum, signed by a qualified actuary, required by Section 41.7(b) of Regulation 143. The actuarial memorandum shall include a discussion of any impact both before and after acceleration, on nonforfeiture values due to the existence of the accelerated death benefit provision. If there is no impact, then the memorandum must include an explanation as to why there is no impact.

Where applicable, this memorandum is required in addition to an actuarial nonforfeiture certification signed and dated by an actuary who is a member in good standing of the American Academy of Actuaries or the Society of Actuaries, that the policy form is in compliance with the nonforfeiture requirements of the New York Insurance Law and regulations applicable to the particular product and that the actuary has read the forms and supporting material submitted with the filing.

E.4) Self Support

Provide a statement of self support in compliance with Section 4228(h) and Circular Letter No. 8 (1998). The Statement must indicate that the cost of providing the accelerated death benefit was considered in the demonstration of self support. Section 41.7(a) of Regulation 143. A statement of self support is not required for group insurance or fraternal organizations.

E.5) Certification of Tax Counsel

Where required, provide tax counsel's written certification that the policy or certificate provides for accelerated payments that qualify under Section 101(g)(3) of the Internal Revenue Code and all other applicable sections of federal law in order to maintain favorable tax treatment. See Section III.D.1of this outline.

E.6) At Issue Disclosure

For accelerated payment of death benefits pursuant to Sections 1113(C) or (D), provide a sample outline of coverage for informational purposes. See Section III.D.2 of this outline.

E.7) Associations coverage pursuant to D Trigger

(a) Insurers issuing policies or riders to an association or its membership that accelerate death benefits pursuant to Section 1113(a)(1)(D) of the Insurance Law must file:

(1) The policy and certificate;

(2) A corresponding outline of coverage;

(3) All advertisements; and

(4) Any other material requested by the Superintendent. See Section VI of this outline.

Section 41.8(x)() of Regulation 143

(b) An insurer issuing insurance to associations must provide the certification required by 41.8(x) if applicable. See Section VI of this outline.

(c) Include the application or claim form used to apply for the acceleration of death benefits. See Sections V.B and V.C of this outline.

(d) Provide certification of tax counsel. See Section III.D of this outline.

III) Accelerated Payment of the Death Benefit

III.A) Definitions

Accelerated death benefit means proceeds payable in part or in full under a life insurance policy, certificate or rider to a policyowner or certificateholder during the lifetime of the insured:

A.1) A Trigger
Pursuant to §1113(a)(1)(A) upon the diagnosis of terminal illness where life expectancy does not exceed 12 months, or a shorter period (for example six months) if specified in the contract ("A Trigger");

A.2) B Trigger
Pursuant to §1113(a)(1)(B) upon the diagnosis of a medical condition requiring extraordinary medical care or treatment regardless of life expectancy ("B Trigger");

A.3) C Trigger
Pursuant to §1113(a)(1)(C) upon certification by a licensed health care practitioner of any condition which requires continuous care for the remainder of the insured's life in an eligible facility or at home when the insured is chronically ill, as defined by §7702B of the Internal Revenue Code ("IRC") and regulations there under, provided the accelerated payments qualify under Section 101(g)(3) of the IRC and all other applicable sections of federal law in order to maintain favorable tax treatment ("C Trigger");

A.4) D Trigger
Pursuant to §1113(a)(1)(D) upon certification by a licensed health care practitioner that the insured is chronically ill, as defined by §7702B of the IRC and regulations there under, provided the accelerated payments qualify under Section 101(g)(3) of the IRC and all other applicable sections of federal law in order to maintain favorable tax treatment;

A.5) E Trigger
Pursuant to §1113(a)(1)(E) and 41.2(a)(5) of Regulation 143, upon the insured's having been a resident of a nursing home, as defined in section 41.2(i) of Regulation 143, for a period of three months or more and upon certification by a licensed health care practitioner that there is an expectation that such insured will remain a resident of a nursing home until death;

A.6) F Trigger
Pursuant to §1113(a)(1)(F) and 41.2(a)(6) of Regulation 143 upon the insured's having been the recipient of end of life or palliative care as defined in 41.2(j) of Regulation 143, for a period of three months or more, at a residential health care facility as defined in 41.2(n) of Regulation 143, home care services as defined in 41.2(d) of Regulation 143 or hospice as defined in section 41.2(e) of Regulation 143, and upon certification of a licensed health care practitioner that there is an expectation that such insured will continue to require such services until death.

III.B) Rules applicable to A, B, C ,D , E, and F triggers

B.1) Any life insurance policy, certificate, or rider that provides accelerated death benefits pursuant to the B, C, D, E or F Trigger must also provide for the accelerated payment of death benefits based on the A Trigger (occurrence of a diagnosis of terminal illness where life expectancy will not exceed 12 months or a shorter period as specified in the policy or rider). Section 3201(c)(11)(A), Section 41.6(a)(3) of Regulation 143. Benefits pursuant to the A Trigger may be provided in a separate form.

B.2) A life insurance policy, certificate, or rider may, in addition to the A Trigger, provide for payment based on the qualifying events of the B, C, D, E and/or F Triggers. The policy, certificate, or rider must specify which of these triggers (singly or in combination) are applicable.

Note: Benefits must be accelerated pursuant to 1113(a)(1)(A), 1113(a)(1)(B), 1113(a)(1)(C) or 1113(a)(1)(D) before benefits may be accelerated pursuant to 1113(a)(1)(E) or 1113(a)(1)(F). Section 41.6(a)(3).

B.3) The accelerated death benefit provision must be effective on the issue date of the policy, certificate, or rider. Section 41.6(b) of Regulation 143.

B.4) If accelerated payment of the death benefit is provided in the policy or certificate, the benefit must be set forth in a separate provision, appropriately captioned as an accelerated death benefit. Section 41.5(x) of Regulation 143.

B.5) There can be no restrictions on the use of the proceeds from the acceleration of death benefits. Section 41.5(o) of Regulation 143.

B.6) The insurer will make no attempt to recover benefits paid upon remission or cure of a terminal illness, medical condition, or chronic illness. Section 41.5(q) of Regulation 143. The insurer must provide written confirmation of compliance with this provision.

B.7) A group life policy shall provide that only the certificateholder has the right to the accelerated death benefit payment. Section 41.5(r) of Regulation 143.

B.8) The insurer may establish a minimum policy issue amount for which accelerated death benefits will be available. Section 41.5(a) of Regulation 143

B.9) The policy shall set forth, if applicable, the minimum and maximum amount that may be accelerated. Sections 41.5(b) of Regulation 143.

B.10) The policy shall describe the effect, if any, of the payment of the accelerated death benefit on any remaining death benefits, nonforfeiture benefits, loan values, and premium payments. Section 41.5(f) of Regulation 143.

B.11) The insurer may require a separate premium charge or cost of insurance charge for the accelerated death benefit. For group policies, the premium may be assessed as part of an experience-based rate or as a separate premium charge. Section 41.5(i) of Regulation 143.

B.12) The policy or certificate (if a certificateholder is required to pay a premium charge associated with an accelerated death benefit) shall disclose any premium charge, cost of insurance and administrative expense charges. Section 41.5(i) of

Regulation 143. The company may reserve the right to charge a fee. Any fee, or a range of fees, must be provided either in the policy (or in a memorandum of variable material) with written assurances that the fee will be applied in a non-discriminatory manner.

B.13) The policy or certificate must describe the effect, if any, of premium charges, cost of insurance charges or administrative charges on the policy dividends or additional amount credited, the period of coverage, account value, nonforfeiture benefits and loan value. Section 41.5(i) of Regulation 143.

B.14) If any death benefit remains after payment of an accelerated death benefit any accidental death benefit provision shall not be affected by payment of the accelerated benefit. Section 41.5(p) of Regulation 143. The insurer must provide written confirmation of compliance with this provision.

B.15) The policy shall specify whether any premium due after the initial accelerated death benefit is established must be paid in cash, whether the payment can be waived, or whether additional accelerated death benefit payments must be made to cover such premiums as they become due. Section 41.5(s) of Regulation 143.

B.16) The policy shall specify the actions required, if any, to prevent termination if future premiums or interest due requires additional acceleration of the death benefit which would result in a total accelerated death benefit payment exceeding the percentage or dollar maximum amount specified in the policy.

The policyowner or certificateholder must always have the right to pay that excess in cash within an applicable grace period in order to prevent termination. Section 41.5(t) of Regulation 143.

B.17) The policy may specify that future premiums or interest becoming due must be paid in cash. Section 41.5(t) of Regulation 143.

B.18) Universal life or variable universal life policies shall specify whether the accelerated death benefit provision would apply to the initial death benefit amount or the current death benefit amount resulting from automatic increases due to Section 7702 of the IRC, or to increases permitted under the terms of the policy, as well as increases that result from operation of the contract. Section 41.5(u) of Regulation 143.

B.19) <u>Existing policyowners or certificateholders</u>

(a) When there is no charge for the attachment of an accelerated death benefit to a policy, then the benefit must be made available to all new issues. The benefit should either automatically be sent to all existing policy holders or those existing policy holders should be given written notification of the availability of the benefit at any time upon their request. Section 3201(c)(2).

(b) When there is a premium charge or cost of insurance charge for accelerated death benefits, the benefit may be offered to existing policyowners or certificateholders by written notification. Written acceptance by the policyowner or certificateholder is required for benefits that provide for a separate premium charge or cost of insurance charge when the policyowner or certificateholder is required to pay these charges. Section 41.6(c) of Regulation 143.

B.20) Except in the case of accelerated death benefits under Insurance Law section 1113(a)(1)(C) or (D), exclusions for the payment of the accelerated death benefit will be permitted only in accordance with the applicable provisions of the Insurance Law pertaining to life insurance. Section 41.5(w) of Regulation 143.

B.21) If an insurer chooses to limit the total accelerated death benefit payments on the insured from policies issued by the insurer, such limitation may not extend to policies issued by an insurer's affiliates.

III.C) <u>Rules applicable to forms providing benefits pursuant to the A Trigger or A and B Triggers</u>

C.1) When accelerated death benefits are provided pursuant to a B Trigger, "a medical condition requiring extraordinary medical care or treatment regardless of life expectancy" must be specified in the policy and may include one or more of the following:

(a) coronary artery disease resulting in an acute infarction or requiring surgery;

(b) permanent neurological deficit resulting from a cerebral vascular accident;

(c) end-stage renal failure;

(d) Acquired Immune Deficiency Syndrome;

(e) invasive cancer;

(f) non-invasive cancer in situ;

(g) permanent paralysis;

(h) major organ transplant; or

(i) other medical conditions which the Superintendent shall deem appropriate.

Section 41.5(h) of Regulation 143.

The certified process may not be used if the policy will accelerate benefits for a medical condition not specified in (a)-(h). Any other condition must be approved by the Department. General statements such as "other medical conditions which the Superintendent will approve" or a benefit that "includes" the specified conditions are not acceptable.

C.2) Exclusions for the payment of the accelerated death benefit provided pursuant to the A or B Trigger must be set forth in the policy/certificate/rider and will be permitted only in accordance with the applicable provisions of the Insurance Law. Section 41.5(w) of Regulation 143.

C.3) The benefit must be fixed at the time the insurer approves the request for the accelerated death benefit. Section 41.5(e)(3) of Regulation 143.

C.4) The policy must include the option to take the benefits in a lump sum. Section 41.5(e)(4) of Regulation 143.

C.5) The policy may provide an election for the payment of accelerated death benefit in installments not less frequently than quarterly, provided such installment is not less than 25% of the actual amount accelerated by the owner. Section 41.5(e)(2) of Regulation 143.

C.6) The aggregate administrative expense charge required for receipt of the accelerated death benefit in installments shall not exceed 110% of the administrative expense charge required for receipt of the accelerated benefit in a lump sum. Section 41.5(g) of Regulation 143.

C.7) The policy may specify a maximum amount that may be accelerated. The policy must permit the policyowner/certificateholder to accelerate at least the lower of 25% of the face amount or $50,000. The policy cannot require (but may allow) the policyowner/certificateholder to accelerate more than 50% of the face amount. Section 41.5(e)(1) of Regulation 143.

C.8) The policy may specify a minimum amount that may be accelerated. Such minimum may not exceed 50% of the policy face amount. Section 41.5(e)(1) of Regulation 143.

C.9) The right to the accelerated death benefit shall continue during any nonforfeiture reduced paid up or extended term period, but may be subject to any policy minimums. The policy may provide that the insured must apply for the accelerated death benefit one year prior to the insurance termination date when extended term insurance is in effect. Section 41.5(v)(1) of Regulation 143.

III.D) <u>Rules applicable to forms providing benefits pursuant to the C and/or D Triggers</u>

D.1) <u>Certification of Tax Counsel</u>

(a) When the form is not intended to be a qualified long term care insurance contract for federal tax purposes, forms accelerating benefits pursuant to the C or D Trigger must include certification of tax counsel that, to the best of the counsel's knowledge and belief, the policy or certificate provides for accelerated payments that qualify under Section 101(g)(3) of the IRC and all applicable sections of federal law in order to maintain favorable tax treatment. Section 41.8(e) of Regulation 143.

(b) When the form is intended to be a qualified long term care insurance contract for federal tax purposes, forms accelerating benefits pursuant to the C or D Trigger must provide a certification of tax counsel as in (a) which also includes a statement that the policy, certificate or rider also meets the requirements of 7702B of the IRC for a qualified long term care contract and the insurer issuing such policy or certificate meets the applicable requirements of Section 4980C of the IRC. Section 41.8(e) of Regulation 143.

D.2) Outline of Coverage

For information purposes, a disclosure statement or outline of coverage must be filed with the submission. See Section 4980C of the Internal Revenue Code for a sample outline format.

(a) The outline of coverage must be a free-standing document, using no smaller than ten point type.

(b) The outline of coverage must contain no material of an advertising nature.

(c) Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

(d) Except as provided in (e) below , the first page of the outline of coverage must prominently display the following:

**Notice to buyer: This policy may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.**

Section 41.8(v)(3) of Regulation 143.

(e) For policies that accelerate death benefits pursuant to Insurance Law section 1113(a)(1)(C) and provide benefits on a per diem basis and are not intended to be qualified long-term care insurance contracts for federal tax purposes, display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and the policy the following:

**Notice to buyer: This policy may not cover all of the costs associated with the chronic illness of the insured. The buyer is advised to review carefully the policy benefits.** Section 41.8(v)(4) of Regulation 143.

D.3) A policy or certificate that is not intended to be a qualified long-term care insurance contract for federal tax purposes shall state that it is not intended to be a qualified long-term care insurance contract under section 7702B of the Internal Revenue Code. Section 41.8(d) of Regulation 143.

D.4) The policy or rider on its face page shall provide for a free look provision for the accelerated death benefits in accordance with the requirements of Section 3203(a)(11) of the Insurance Law, which shall not be less than 30 days. Section 41.8(g) of Regulation 143.

D.5) "Chronically ill" means any individual who has been certified by a licensed health care practitioner as

(a) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity;

(b) having a level of disability similar to the level of disability described in (a); or

(c) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Section 7702B(c)(2) of the Internal Revenue Code.

D.6) Benefits must be retroactive to the beginning of the 90 day period that is certified to by the licensed health care practitioner (the eligibility period.) An elimination period is not authorized by Regulation 143.

D.7) The policy, certificate or rider may provide that the 90 day eligibility period may be satisfied by non-consecutive days, as long as the 90 days occur within a period of time specified in the policy, certificate or rider.

D.8) The right to the accelerated death benefit shall continue during at least one of the following paid up nonforfeiture options, but may be subject to any policy minimums:

(a) reduced paid-up insurance;

(b) extended term insurance;

(c) other similar offerings approved by the Superintendent.

In the event the right to continue the accelerated death benefit is not available due to policy minimums, then there shall be an equitable adjustment in the paid up life insurance provided. Section 41.5(v)(2) of Regulation 143.

D.9) No policy or certificate shall limit or exclude the acceleration of death benefit by type of illness, treatment, medical condition or accident except:

(a) mental or nervous disorders, excluding Alzheimer's Disease or demonstrable organic brain disease;

(b) alcoholism or drug addiction;

(c) illness, treatment or medical condition arising out of:

(i) war or act of war (whether declared or undeclared);

(ii) participation in a felony, riot or insurrection;

(iii) service in the armed forces or unit auxiliary thereto;

(iv) suicide, attempted suicide or intentionally self-inflicted injury; or

(v) aviation (this exclusion applies only to non-fare paying passengers);

(d) treatment provided in a government facility (unless otherwise required by law), services for which benefits provided under Medicare or other governmental program (except Medicaid), any state or federal worker's compensation, employer's liability or occupational disease law, or any mandatory motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance; and

(e) treatment or care received outside the United States and its possessions.

Section 41.8(h) of Regulation 143.

D.10) Payment of benefits:

(a) Payments may be made for costs incurred for qualified long-term care services or made on a per diem basis without regard to the expenses incurred for qualified long-term care services. Section 41.8(f) of Regulation 143. The policy or certificate must disclose whether payments will be made on a cost incurred or per diem basis.

(b) The policy or certificate may pay a per diem benefit provided that the per diem benefit does not exceed the maximum amount eligible under Section 101(g)(3) of the Internal Revenue Code and all other applicable sections of federal law for favorable tax treatment.

Section 41.8(o) of Regulation 143.

(c) Except as provided in (d) , the first page of the policy must prominently display the following:

**Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.**

Section 41.8(v)(3) of Regulation 143.

(d) For policies that accelerate death benefits pursuant to Insurance Law section 1113(a)(1)(C) and provide benefits on a per diem basis and are not intended to be qualified long-term care insurance contracts for federal tax purposes, display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and the policy the following:

**Notice to buyer: This policy may not cover all of the costs associated with the chronic illness of the insured. The buyer is advised to review carefully the policy benefits.**

Section 41.8(v)(4) of Regulation 143

D.11) The policy or certificate shall not condition eligibility for any benefits on a prior hospitalization requirement or condition eligibility for benefits provided in an institutional care setting on the receipt of a higher level of care or condition eligibility of non-institutional benefits on the prior receipt of institutional care. Section 41.8(i) of Regulation 143.

D.12) The policy or certificate shall provide in the incontestable provision in addition to the requirements of Insurance Law section 3203(a)(3) or 3220(a)(1), as applicable:

(a) A provision that a policy or certificate that has been in force for at least six months but less than two years may be rescinded or an otherwise valid claim for accelerated benefits may be denied upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought; and

(b) If increases are permitted, that any increase in the policy or certificate that has been in effect for at least six months but less than two years which was applied for and subject to evidence of insurability may be rescinded, or an otherwise valid claim for accelerated benefits on the amount of the increase may be denied, upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought. Section 41.8(j) of Regulation 143.

D.13) The policy or certificate may provide for a maximum monthly amount that may be accelerated, which maximum amount may differ based on whether the insured is receiving qualified care services at home or in a long-term care facility. Section 41.8(k) of Regulation 143.

D.14) The policy or certificate may include a provision that suspends the right to accelerate less than all of the death benefit due to a diagnosis of terminal illness while the death benefit is being accelerated pursuant to the C Trigger or D Trigger. Section 41.8(m) of Regulation 143.

D.15) The conversion benefit available pursuant to Sections 3220(a)(6) or 3220(a)(7) of the Insurance Law shall include a benefit comparable to the acceleration benefit. This requirement may be satisfied by a separate policy or certificate. This requirement, subject to the approval of the Superintendent, may be satisfied by arrangement with another insurer to provide the required coverage. Section 41.8(n) of Regulation 143.

D.16) When payment of an accelerated death benefit results in a pro-rata reduction in cash value, the payment may either: be applied toward repaying a portion of loan equal to a pro rata portion of any outstanding policy loans; be applied entirely to pay qualified long term care expenses; or distributed as long term care payments. If part of the payment is not used to repay a portion of any outstanding policy loan, then the policyowner or certificateholder must be provided with a disclosure of the effect of acceleration upon any remaining death benefit, cash value or accumulation amount, policy loan and premium payments, including a statement of the possibility of termination of any remaining death benefit. The policyowner or certificateholder shall provide written consent authorizing any other arrangement for the repayment of outstanding policy loans. Section 41.8(q) of Regulation 143.

D.17) The policy or certificate must be clear on how any increases or decreases in the face amount and/or death benefit other than decreases due to the payment of an accelerated death benefit affect the amount of the death benefit that may be accelerated. Section 41.8(t) of Regulation 143.

D.18) If a claim is denied, the insurer shall, within 60 days of receipt of a written request by a policyowner or certificateholder, provide a written explanation of the reasons for the denial and make available all information directly related to such denial.

Section 3201(c)(2), Internal Revenue Code §4980C(c)(3). The policy, certificate or rider may not be in conflict with this requirement.

D.19) If a policy, certificate or rider providing a benefit pursuant to the C or D Triggers refers to a timeframe for any of the following items, the timeframe must comply as follows:

(a) Any required time frame for the policyowner or certificate holder to file a notice of claim must be no sooner than 60 days after the covered loss began, or, if not reasonably possible, as soon as reasonably possible. Section 3201(c)(2).

(b) Any required time frame for the policyowner or certificateholder to provide proof of loss may be no sooner than 90 days after the first covered long-term care service began or, if not reasonably possible, as soon as reasonably possible, but not later than one year, except in the case of incapacity. Section 3201(c)(2).

(c) Any required time frame for providing continuing proof of receipt of covered services may be no more frequent than once every 31 days. Section 3201(c)(2).

(d) Any required timeframe for providing periodic proof of chronic illness may be no more frequent than once every 90 days. Section 3201(c)(2).

III.E) <u>Additional rules applicable to forms intended to be qualified long-term care insurance contracts for federal tax purposes</u>.

E.1) All provisions applicable to the C triggers, discussed in section III.D of this outline are applicable to products with a D trigger.

E.2) For forms intended to be qualified long-term care insurance contract for federal tax purposes shall:

(a) meet the applicable requirements of section 4980C of the Internal Revenue Code for a qualified long-term care insurance carrier;

(b) meet all the applicable requirements of section 7702B of the Internal Revenue Code, as amended for a qualified long-term care insurance contract or payments; and

(c) state that it is intended to be a qualified long-term care insurance contract under Section 7702B of the IRC and must contain this statement:

**This is not a health insurance (policy)(certificate) and is not subject to the minimum requirements of New York Law pertaining to Long-**

**Term Care Insurance and does not qualify for the New York State Long Term Care Partnership Program and is not a Medicare Supplement Policy. The (policy)(certificate) is intended to be a qualified long-term care insurance contract for federal tax law only.**

Section 41.8(c) of Regulation 143.

E.3) In addition to the requirements of Section 3203(a)(10), the policy/rider/certificate must include a provision for reinstatement of coverage in the event of lapse if the insurer is provided proof of cognitive impairment or the loss of functional capacity. This option must be available to the insured if requested within five (5) months after termination and may allow for the collection of past due premium, where appropriate.

The standard of proof of cognitive impairment or loss of functional capacity cannot be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy, rider or certificate. Section 41.8(aa)(4) of Regulation 143. See Section III.D of this outline.

E.4) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge must be set forth in the policy, rider or endorsement. Section 41.8(ab)(3) of Regulation 143.

E.5) Except for policies or certificates that are guaranteed issue, the following language, or language substantially similar to the following, shall be set out conspicuously in bold type on the policy or certificate at the time of delivery:

**Caution: The issuance of this (policy)(certificate) is based upon your responses to the questions on your (application)(enrollment form). A copy of your (application)(enrollment form) (is enclosed)(was retained by you when you applied). If your answers fail to include all material information requested, the company has the right to deny benefits or rescind your (policy)(certificate). The best time to clear up any questions is now, before a claim arises! If for any reason, any of your answers are incorrect, contact the company at this address: (insert address).**

Section 41.8(ac)(3)(ii) of Regulation 143.

E.6) An insurer may not limit or exclude benefits provided for home health care or community care services:

(a) by requiring that the insured/claimant would need care in a skilled nursing facility if home health care services were not provided;

(b) by requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home, community or institutional setting before home health care services are covered;

(c) by limiting eligible services to services provided by registered nurses or licensed practical nurses;

(d) by requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

(e) by excluding coverage for personal care services provided by a home health aide;

(f) by requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(g) by requiring that the insured/claimant have an acute condition before home health care services are covered;

(h) by limiting benefits to services provided by Medicare-certified agencies or providers; or

(i) by excluding coverage for adult day care services.

Section 41.8(ae)(1) of Regulation 143.

E.7) if a policy/certificate/rider provides for home health or community care services, it must provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits at the time covered home health or community care services are being received. This requirement does not apply to policies issued to residents of continuing care retirement communities. Section 41.8(ae)(2) of Regulation 143.

E.8) Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate. Section 41.8(ae)(3) of Regulation 143.

E.9) The termination of the accelerated death benefits must be without prejudice to any benefits payable for any claim pursuant to the C or D Trigger if such claim began while the accelerated death benefits were in force and continues without interruption after termination. Such extension of benefits beyond the period the insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy. Section 41.8(af) of Regulation 143.

IV) Options for Payment of Accelerated Death Benefits

IV.A) Per Diem/Cost Incurred

See Section III.D.10 for options regarding per diem/cost incurred payment of accelerated death benefits applicable to the C and D Triggers.

IV.B) Discounted acceleration of the death benefit by mortality and/or interest.

An insurer may pay a discounted death benefit. The calculation must be based on any applicable actuarial discount appropriate to the policy design. The interest rate or interest rate methodology used in the calculation and its application must be disclosed in the policy. Section 41.5(j) of Regulation 143.

In no event may the maximum interest rate exceed the greater of:

(a) the then current yield on the 90-day Treasury Bills available at the date of application for an accelerated payment; and

(b) the then current maximum adjustable policy loan interest rate based on the greater of:

(i) Moody's Corporate Bond Yield Averages – Monthly Average Corporates - published by Moody's Investors Services, Inc. or any successor thereto for the calendar month ending two months before the date of the application for an accelerated payment; and

(ii) the policy guaranteed cash value interest rate plus one per centum per annum (1%).

Section 41.5(j) of Regulation 143.

IV.C) Lien approach

C.1) The payment of any accelerated death benefit, any administrative expense charges, any future premium and any accrued interest can be considered a lien against the death benefit of the policy and the access to the cash value may be restricted to any excess of the cash value over the sum of any other outstanding loans and the lien. Future access to additional policy loans and partial withdrawals may also be limited to any excess of the cash value over the sum of the lien and any other outstanding policy loans. Section 41.5(l) of Regulation 143.

C.2) Under the lien approach, the insurer may accrue an interest charge on the amount of the accelerated benefits. The interest rate or interest rate methodology used in

the calculation and its application must be disclosed in the policy. Section 41.5(l) of Regulation 143.

C.3) In no event may the maximum interest rate used exceed the greater of:

(a) the then current yield on the 90-day Treasury Bills available on the date of application for an accelerated death benefit; or

(b) the higher of:

(i) the then current maximum adjustable policy loan interest rate based on Moody's Corporate Bond Yield Averages - Monthly Average Corporates - published by Moody's Investors Service, Inc. or any successor thereto, for the calendar month ending two months before the date of application for an accelerated payment; and

(ii) the policy guaranteed cash value interest rate plus one per centum per annum (1%).

Section 41.5(l) of Regulation 143.

C.4) The interest rate accrued on the portion of the lien which is equal in amount to the cash value of the policy at the time of the benefit acceleration may be no more than the policy loan interest rate. Section 41.5(l) of Regulation 143.

C.5) Under the lien approach, if the policy terminates while the lien described above is outstanding, the insurer shall extinguish the lien without further recourse to the policyowner or certificateholder. In the event the policy is reinstated, the lien may also be reinstated with interest accrued as if the policy or certificate had never terminated. Section 41.5(m)(1) of Regulation 143.

C.6) Under the lien approach, the policyowner/certificateholder must have the option of paying all or part of any premium or accrued interest that would be capitalized under the term of the policy provisions, as well as the option of repaying all or part of any lien in cash, in order to prevent the lien from causing a termination. Section 41.5(m)(2) of Regulation 143.

IV.D) Any additional accelerated death benefits pursuant to the C and D Trigger payable in excess of the death benefit may only be provided if there are no premium requirements for such benefits, once those benefits are being paid. Section 41.5(c) of Regulation 143.

IV.E) When an accelerated death benefit is payable, there must be no more than a pro rata reduction in the cash value based on the percentage of death benefits accelerated to produce the accelerated benefit payment. Section 41.5(k) of Regulation 143.

IV.F) When payment of an accelerated death benefit pursuant to an A or B Trigger results in a pro rata reduction in account value or nonforfeiture benefits, the payment shall be applied toward repaying a portion of loan equal to a pro rata portion of any outstanding policy loans, unless the policyowner/certificateholder is provided with a disclosure of the effect of acceleration upon any remaining death benefit, account value, nonforfeiture benefits, policy loan and premium payments, including a statement of the possibility of termination of any remaining death benefit. A policyowner/certificate holder shall provide written consent authorizing a different percentage. Section 41.5(n) of Regulation 143.

V) Applications, applications for benefits, and claim forms.

Applications for a policy/rider/certificate with an accelerated death benefit and applications and claim forms for accelerating death benefits are subject to the requirements of Section V.A, below. Requirements for Applications/claim forms for acceleration of benefits pursuant to C are also subject to the requirements of V.B. Applications/claim forms for acceleration of death benefits pursuant to the D Trigger must meet the requirements of both Sections V.B and V.C.

V.A) Application and claim form requirements

A.1) An application for a life insurance policy or an enrollment form for group life coverage providing for accelerated payment of death benefits pursuant to an A or B trigger or a C or D trigger that is not intended to be a qualified long-term care insurance contract for federal tax purposes must contain a prominent notice stating:

**Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.**

Section 3230(a)(1), Section 41.4(c)(1) of Regulation 143.

(a) This notice must include the amount of any separate premium charge or cost of insurance charge (except for non-contributory group life). Section 3230(a)(2), Section 41.4(c)(1) of Regulation 143.

(b) This notice must disclose whether a discount or lien is associated with the acceleration and any administrative charge required upon the exercise of the benefit. Section 41.4(c)(1) of Regulation 143.

We have permitted insurers to provide the notice described above in a separate form until the next reprinting of the application form to include the required language. The separate notice must be submitted for review and approval. Once the application is reprinted to include the notice it must be resubmitted for approval with a distinguishing form identification number.

A.2) The application for a life insurance policy or an enrollment form for group life coverage providing for accelerated payment of death benefits pursuant to Insurance Law section 1113(a)(1)(C) or (D) that is intended to be a qualified long-term care insurance contract for federal tax purposes shall contain a prominent notice stating;

**Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income and may be taxable.**

Section 41.4(c)(2) of Regulation 143.

A.3) The application for a life insurance policy or an enrollment form for group life coverage providing for accelerated payment of death benefits pursuant to Insurance Law section 1113(1)(E) or (F) shall contain a prominent notice stating:

**Receipt of accelerated death benefits affects eligibility for public assistance programs and this type of accelerated death benefit is not expected to receive the same favorable tax treatment as other types of accelerated death benefits that may be available to you.**

The notice, except for noncontributory group life coverage, shall also include the amount of any separate premium charge or cost of insurance charge. If no separate identifiable premium or cost of insurance charge is made, the notice shall disclose:

(a) whether a discount or lien is associated with the acceleration; and

(b) any administrative charge required upon the exercise of the benefit.

Section 41.4(c)(3) of Regulation 143.

A.4) The application or claim form to accelerate benefits must provide the following directly above the policyowner's or certificateholder's signature:

(a) A notice prominently displayed to read:

**Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, (policyowners)(certificateholders) should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents.**

Section 3230(b)(2), Section 41.4(e)(1) of Regulation 143.

(b) A notice prominently displayed to read:

**Receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, (policyowners) (certificateholders) should seek assistance from a qualified tax advisor.**

Section 3230(b)(3), Section 41.4(e)(2) of Regulation 143.

For policies that accelerate pursuant to Insurance Law section 1113(a)(1)(E) or (F), the disclosure shall further state:

**Receipt of this type of accelerated death benefit is not expected to receive the same favorable tax treatment as other types of accelerated death benefits that may be available to you**

**Section 41.4(e)(2) of Regulation 143.**

The sentences pertaining to the differing treatment of lump sum and periodic payments are optional in products that provide only one form of payment.

(c) A statement by the policyowner or certificateholder that such application is voluntary and without coercion on the part of any third party. Section 3230(b)(4), Section 41.4(e)(3) of Regulation 143.

(d) A statement that no health care facility, as defined in Section 20 of the Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility. Section 41.4(e)(4) of Regulation 143.

(e) A statement setting out the remaining death benefits, if any, available to the beneficiary. Section 3230(b)(5), Section 41.4(e)(5) of Regulation 143.

(f) A notice that the insurer is prohibited from paying accelerated death benefits to the policyowner or certificateholder for a period of 5 days from the date on which the illustrations, computations and notice required by Section 41.4(f) are transmitted in writing to the policyholder or certificateholder. The policyowner or certificateholder shall have the right to rescind the request for such payments at any time during the process of application for benefits. Section 3230(c) and Section 41.4(e)(6) of Regulation 143.

(g) The application must be dated by the insurer upon transmittal and be completed and signed by the policyowner or certificateholder not more than 30 days thereafter. Section 41.4(e)(7) of Regulation 143. A statement of this requirement should appear in the application.

V.B) Requirements applicable to acceleration pursuant to C Trigger and D Trigger:

B.1) For insurers that elect to coordinate benefits and that will only make payments if the payments will receive favorable tax treatment by the federal government, the claim form to receive benefits shall include the following statement:

**Benefit payments will only be made if the payments are subject to favorable tax treatment by the federal government. Receipt of benefit payments from multiple policies exceeding the applicable limits may result in tax consequences. Therefore, when determining whether the benefit payments will receive favorable tax treatment, the payment of benefits from all insurance policies must be considered.**

Section 41.8(z)(1) of Regulation 143.

B.2) The claim form must include a question as to whether the insured is covered by other insurance policies that will pay similar benefits. Section 41.8(z)(1)(i) of Regulation 143.

B.3) The insurer shall have written procedures for use during the claim handling process for confirming that the benefit payments at the time of their payment are expected to receive favorable tax treatment by the federal government. Section 41.8(z)(1)(ii) of Regulation 143.

B.4) For insurers that do not elect to coordinate benefits, the claim form to receive benefits pursuant to this section shall include the following statement:

**Benefit payments may not be subject to favorable tax treatment by the federal government. When determining whether the benefit payments will receive favorable tax treatment, the payment of benefits from all insurance policies must be considered. Receipt of benefit payments under multiple policies exceeding the applicable limits may result in tax consequences. This insurer does not coordinate benefits to ensure that the payments receive favorable tax treatment by the federal government. Accordingly, prior to applying for benefits, you should seek assistance from a qualified tax advisor.**

Section 41.8(z)(2) of Regulation 143.

V.C) Additional requirements applicable to policies that are intended to be qualified long-term care insurance contracts for federal tax purposes

C.1) Designation/Waiver

(a) The application form must provide a space clearly designated for listing at least one person to whom notice may be given in the event of lapse or termination of the policy or certificate for nonpayment of premium. The application shall include each person's full name and home address. Section 41.8(aa)(1) of Regulation 143.

(b) If the applicant elects not to designate an additional person to receive notice, the applicant must provide a waiver. The waiver shall state:

**Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice.**

Section 41.8(aa)(1) of Regulation 143.

(c) Before issue of policy, the insurer must receive from applicant either the written designation of at least one person who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium; or written waiver dated and signed by the applicant electing not to designate additional persons to receive notice.

Section 41.8(aa)(1) of Regulation 143.

(d) No less often than once every two years, the insurer shall notify the insured of the right to change the written designation. Section 41.8(aa)(1) of Regulation 143.

(e) When the policyowner or certificateholder pays the premium for the policy or certificate through a payroll or pension deduction plan, the notice and waiver requirements need not be met until sixty (60) days after the policyowner or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates must clearly indicate the payment plan selected by the applicant. Section 41.8(aa)(2) of Regulation 143.

C.2) Except for policies or certificates that are guaranteed issue, the following language must be set out in bold type, conspicuously and in close conjunction

with the applicant's signature block on an application for a policy or enrollment form for a certificate:

**Caution: If your answers on this (application)(enrollment form) fail to include all material information requested, (company) has the right to deny benefits or rescind your (policy)(certificate).**

Section 41.8(ac)(3)(i) of Regulation 143.

C.3) A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the delivery of the policy or certificate unless it was retained by the applicant at the time of application. Section 41.8(ac)(4) of Regulation 143.

V.D) Special Rules for Benefits Accelerated pursuant to 1113(a)(1)(E) and 1113(a)(1)(F)

D.1) The Circular Letter No. 6 (2004) process is not permitted for benefits accelerated under Sections 1113(a)(1)(E) and 1113(a)(1)(F) without prior permission from the Department.

D.2) Any policy providing benefits pursuant to Insurance Law section 1113(a)(1)(E) or (F) shall provide that the death benefit will first be accelerated under any Insurance Law section 1113(a)(1)(A), (B), (C) or (D) triggers for which the policyowner or certificateholder qualifies under the same policy. Section 41.6(a)(3) of Regulation 143.

D.3) In the case of accelerated payment of death benefits pursuant to Insurance Law section 1113(a)(1)(E) or (F), the policy or rider on its face page shall state "Receipt of this type of accelerated death benefit is not expected to receive the same favorable tax treatment as other types of accelerated death benefits that may be available to you. Prior to applying for benefits, you should seek assistance from a qualified tax advisor." Section 41.4(d).

D.4) The policy may specify a maximum amount that may be accelerated. The policy must permit the policyowner/certificateholder to accelerate at least the lower of 25% of the face amount or $50,000. The policy cannot require (but may allow) the policyowner/certificateholder to accelerate more than 50% of the face amount. Section 41.5(e)(1) of Regulation 143.

D.5) The policy may specify a minimum amount that may be accelerated. Such minimum may not exceed 50% of the policy face amount. Section 41.5(e)(1) of Regulation 143.

D.6) The benefit must be fixed at the time the insurer approves the request for the accelerated death benefit. Section 41.5(e)(3) of Regulation 143.

D.7) The policy must include the option to take the benefits in a lump sum. Section 41.5(e)(4) of Regulation 143.

VI) Special rules applicable to insurers issuing policies/riders/certificates to associations where the policy/rider/certificate provides for the acceleration of death benefits pursuant to C or D Trigger.

VI.A) An insurer must not issue a policy or certificate that includes a C or D Trigger accelerating death benefits to an association or its membership unless the insurer has filed the following with the Department:

A.1) the policy/rider/certificate,

A.2) a corresponding outline of coverage,

A.3) all advertisements, and

A.4) any other material requested by superintendent.

Section 41.8(x)(2) of Regulation 143

VI.B) The insurer must submit with initial filing and annually thereafter by December 31, certification that:

B.1) All compensation to the association complies with all applicable statutes and regulations.

B.2) When making insurance under this section available to its members, the association has:

(a) taken steps to educate its members concerning long term care issues so that its members can make informed decisions; and

(b) furnished only objective information as provided by the insurer regarding the policies or certificates that are available to the association's members;

B.3) Any solicitation for insurance under this section

(a) discloses the specific nature of any compensation arrangements, including the amount that the association or any of its related entities receives, with respect to the insurance;

(b) includes a brief description of the process under which such policies or certificates and the insurer issuing such policies or certificates were selected; and

(c) if the association and the insurer have interlocking directorates or trustee arrangements, discloses such fact to the members;

Section 41.8(x)(3) of Regulation 143.

B.4) The board of directors of an association making the insurance policies or certificates available to its members has reviewed and approved such insurance policies or certificates as well as the compensation arrangements made with the insurer, and

B.5) The association has:

(a) engaged the services of a licensed insurance consultant or licensed insurance producer with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies and certificates, including benefits, features, and rates, at the time of the association's decision to have the insurance made available to its members and at the time of any material change;

(b) established procedures to actively monitor the marketing efforts of the insurer and its agents; and

(c) reviewed and approved all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

Section 41.8(x)(3) of Regulation 143.