

PRODUCT OUTLINE
INDIVIDUAL HOSPITAL INDEMNITY PRODUCT OUTLINE
As of 7/13/04

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I. Key References

Key Insurance Law Sections – 3102, 3105, 3201 (Form Approval issues), 3216 especially 3216 (d)(1)(2) (standard provisions), 3204 (contract/application issues).

Key Applicable Regulations – Regulation 62 (11 NYCRR 52) minimum standards for form, content and sale of health insurance including Sections 52.2, 52.10, 52.16, 52.17, 52.31, 52.33, 52.40, 52.41, 52.43, 52.45 (minimum loss ratio standards), 52.51 (applications), 52.53 (conditional receipts/interim insurance agreements), 52.54 and 52.59 (disclosure requirements), Regulation 169 (11 NYCRR 420) privacy of consumer financial and health information including Section 420.18.

Key Circular Letters – Circular Letter No. 23 (1976), Circular Letter No. 3 (1989), Circular Letter No. 5 (1997)

II. Cover Page

1. Company's Name and Address (New York State licensed entity).
2. Full street address of the company's home office in prominent place (generally front and back of policy form) for disclosure purposes.
3. No unlicensed entity in New York State should appear on the form. – Section 3201 (c)(1).
4. Include name of product on the form within the defined category of Section 52.10 of Regulation 62.
5. Include "free look" provision within parameters of Section 3216 (c)(10).
6. Form identification number in lower left-hand corner of form – Section 52.31 (d).
7. Renewability provisions of form to be placed on the front page of the policy form – Section 52.17 (a)(1)(2).
8. If renewability provisions are "noncancellable" and/or "guaranteed renewable", must comply with Sections 52.17 (a)(5)(6)(7) of Regulation 62. In general for hospital indemnity forms, the terms "noncancellable" or "noncancellable and guaranteed renewable" can only be used in a form which the insured has the right to continue in force by the timely payment of premiums as set forth in the form until age 65. During this renewal period, the insurer has no right to make unilaterally any change in any provision of the form while the form is in force. When the term "guaranteed renewable" is to be used alone without using the term "noncancellable" in conjunction with the term "guaranteed renewable", the term "guaranteed renewable" may only be used in a form which the insured has the right to continue in force by the timely payment of premiums until age 65. During this renewal period, the insurer has no right to make unilaterally any change in any provision of the form while the form is in force except the insurer may make changes in premium rates by classes.

A hospital indemnity form using rates predicated upon a level premium age-at-issue basis must contain renewal provisions which are guaranteed renewable, noncancellable or provide nonrenewal is subject to the consent of the superintendent. This is required so that an insurer does not unjustifiably nonrenew level premium forms to keep reserves based upon a level premium rating methodology - Section 52.40(b)(1)

Section 3216(f) requires that coverage be provided for any time period the insurer accepts premium. Sometimes a hospital indemnity form terminates at a stated age or has a date after which coverage provided by the policy will not be effective. If the hospital indemnity insurer

accepts premium for a time period during which the stated termination age or the stated coverage termination date occurs, the hospital indemnity insurer must provide coverage to the end of the time period during which the stated termination age or stated coverage termination date occurs. The insurer needs to take affirmative action to ascertain whether a person will reach a stated termination age or stated coverage termination date to determine whether premium should be accepted.

9. Signature of Officer(s) – signature of one or more company officers should appear on the face page to execute the contract on behalf of the company.

III. Policy Schedule Page

1. Complete with hypothetical data – Section 52.31 (f).
2. Premium summary amounts and provisions dealing with insured participation status in surplus or dividends should appear – originates from Section 52.31 (f) and Section 3216 (c)(1).
3. Per diem hospital confinement benefits, maximum benefit periods and similar optional choices made by the insured should be set forth – originates from Section 52.31 (f) and Section 3204 (a)(1).
4. Name of insured space – originates from Section 52.31 (f) and Section 3216 (c)(3).
5. Spaces for effective date of insurance, renewal dates and renewal terms – originates from Section 52.31 (f) and Section 3216 (c)(2).
6. Optional choices of insured regarding certain benefits and/or riders should be set forth – originates from Section 52.31(f) and Sections 3204(a)(1).

IV. Table of Contents must be included when required by Section 3102 (c)(1)(G).

V. Mandatory Standard Contract Provisions

1. Must include “Entire Contract; Changes” provision with no incorporation by reference to writings not part of the form – Section 3216 (d)(1)(A), Section 3204(a)(1).
2. Must include “Time Limit on Certain Defenses” provision in accordance with statutory options. Section 3216 (d)(1)(B)(i) allows the insurer to have two options regarding application misstatements for an individual hospital indemnity policy and the ability of the insurer to void the policy or deny a claim due to misstatements. The first option allows the insurer to void the policy or deny a claim for loss incurred or disability commencing within the first two years of the policy issuance date on the basis of application misstatements. For fraudulent misstatements in the application, there is no two-year time limit on the ability of the insurer to void the policy or deny a claim for loss incurred or disability commencing from the date of policy issuance. The second option is available only for a policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue. This second option would be available to individual hospital indemnity insurers which issue “noncancellable” or “guaranteed renewable” policies within the meaning of Sections 52.17 (a)(5)(6)(7) of Regulation 62. This second option requires the insurer to label this option as “Incontestable” and not “Time Limit on Certain Defenses”. This option indicates that, once the policy has been in force for two years during the lifetime of the insured, the policy is incontestable as to any statements contained in the application.

At the insurer's option, the insurer may add a statutory phrase extending the calculation of the two-year period by any period of disability of the insured.

Insurers are reminded these are two distinct statutory options, and the most favorable aspects for an insurer cannot be made into a third option not sanctioned by statute. For example, the fraudulent misstatement exception of the first option cannot be added to the second option.– Section 3216 (d)(1)(B).

Must include a preexisting condition time period complying with Section 3216(d)(1)(B)(ii) when the hospital indemnity policy is medically underwritten and issued to persons under age 65.

Section 3216(d)(1)(B)(ii) sets a two-year time period from the coverage issuance date for a hospital indemnity insurer to exclude coverage for preexisting conditions when the hospital indemnity policy is medically underwritten and issued to persons under age 65. For hospital indemnity coverage, it is important to note that Section 52.2(v) defines a preexisting condition as the existence of symptoms which would ordinarily cause a prudent person to seek diagnosis, care or treatment within a two-year period preceding the effective date of coverage or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a two-year period preceding the effective date of coverage.

Hospital indemnity coverage may include benefits based upon disability (such as incidental benefits paid when an insured meets a definition of total disability), and for those disability based benefits, if the disability commences after two years from the coverage issuance date, the disability based benefits are not subject to a pre-existing condition limitation. However, the indemnity benefits paid for hospital confinements and other sickness or injury benefits (benefits unrelated to disability definitions) are subject to the "loss incurred" wording of Section 3216(d)(i)(B)(ii). Losses unrelated to disability definitions which occur within the first two years of policy issuance and continue past two years from policy issuance are covered on the 731st day from the coverage issuance date.

Please note that, for hospital indemnity coverage issued on the basis of an application which does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment (i.e. – "guaranteed issue"), pre-existing condition limitations after the policy issuance date are limited to no greater than 12 months. – 52.17(a)(27)

Please note that, for hospital indemnity coverage issued to persons age 65 and older, pre-existing condition limitations after the policy issuance date are limited to no greater than six months. – 52.17(a)(28)

Conditions of an insured not considered preexisting conditions within the meaning of Section 52.2(v) are not subject to any preexisting condition limitation. In that instance these conditions would be covered immediately after the coverage issuance date.

3. Must include "Grace Period" provision for premium payment in accordance with statutory options – Section 3216 (d)(1)(C).
4. Must include "Reinstatement" provision in case of form lapse in accordance with statutory options. Section 3216 (d)(1)(D) of the Insurance Law makes reference to a conditional receipt when premium is tendered with an application for reinstatement. Insurers are reminded that the conditional receipt used for reinstatement of individual hospital indemnity forms has its own statutory requirements for use in the reinstatement situation. For example, Section 3216 (d)(1)(D) of the Insurance Law places a maximum 45-day time limit following the date of the conditional receipt for insurer action on a reinstatement application where the

insurer or its agent issued a conditional receipt for premium tendered. The form is reinstated on the 45th day following the conditional receipt date if the insurer has not approved or disapproved the reinstatement application in writing within that time period. - Section 3216 (d)(1)(D).

5. Must include “Notice of Claim” provision in accordance with statutory options – Section 3216(d)(1)(E)
6. Must include “Claim Forms” provision – Section 3216 (d)(1)(F).
7. Must include “Proofs of Loss” provision – Section 3216 (d)(1)(G).
8. Must include “Time of Payment of Claims” provision in accordance with statutory options – Section 3216 (d)(1)(H).
9. Must include “Payment of Claims” provision in accordance with statutory options – Section 3216 (d)(1)(I).

Section 3216 (d)(1)(I) contains several scenarios and/or options for the insurer. Each scenario and/or option chosen must be as favorable or more favorable than Section 3216 (d)(1)(I).

10. Must include “Physical Examinations and Autopsy” provision – Section 3216 (d)(1)(J).
11. Must include “Legal Actions” provision – Section 3216 (d)(1)(K).
12. When applicable, must include “Change of Beneficiary” provision in accordance with statutory options – Section 3216 (d)(1)(L).
13. When applicable, must include “Conversion Privilege” provision – Section 3216 (d)(1)(M).

VI. Optional Standard Provisions

1. If insurer chooses to place a “Change of Occupation” provision in the coverage, must comply with Section 3216(d)(2)(A).
2. If insurer chooses to place a “Misstatement of Age” provision in the coverage, must comply with Section 3216 (d)(2)(B).
3. If insurer chooses to place an “Other Insurance in this Insurer” provision in the coverage, must comply with Section 3216 (d)(2)(C).
4. If insurer chooses to place an “Insurance with Other Insurers” provision in the coverage, must comply with Section 3216 (d)(2)(E).
5. If insurer chooses to place an “Unpaid Premium” provision in the coverage, must comply with Section 3216 (d)(2)(G).
6. If insurer chooses to place a “Cancellation” provision in the coverage, must comply with Section 3216 (d)(2)(H).
7. If insurer chooses to place a “Conformity with State Statutes” provision in the coverage, must comply with Section 3216 (d)(2)(I).

8. If insurer chooses to place an “Illegal Occupation” provision in the coverage, must comply with Section 3216 (d)(2)(J). See also Section 52.16 (c)(4)(i) of Regulation 62.
9. If insurer chooses to place an “Intoxicants and Narcotics” provision in the coverage, must comply with Section 3216 (d)(2)(K).

VII. Permissible Exclusions and Limitations on Coverage*

1. If insurer chooses to place a preexisting condition limitation in the coverage, must comply with Sections 52.16 (c)(1) and 52.2(v) of Regulation 62 and Section 3216 (d)(1)(B)(ii) of the Insurance Law. (see V.2. above also.)
2. If insurer chooses to place an exclusion or limitation on coverage for mental or emotional disorders, alcoholism or drug addiction must comply with Section 52.16 (c)(2) of Regulation 62 and Section 3216 (d)(2)(K) as pertinent.
3. If insurer chooses to place an exclusion or limitation on coverage for pregnancy, must comply with Section 52.16 (c)(3) of Regulation 62. For hospital indemnity coverage which does not provide hospital, medical or surgical expense coverage within the meaning of Section 3216(g)(1) of the Insurance Law or Section 360.2(c) of Regulation 145 (11 NYCRR 360), please see Circular Letter No. 23 (1976), question 2.
4. If insurer chooses to place an exclusion or limitation on coverage for war or act of war, suicide, attempted suicide or intentionally self-inflicted injuries, must comply with Section 52.16 (c)(4) of Regulation 62.

If insurer chooses to place an exclusion or limitation on coverage for participation in a felony, riot or insurrection, service in the armed forces or units auxiliary thereto, aviation (other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline), must comply with Section 52.16 (c)(4). For felony participation, see also Section 3216 (d)(2)(J) of the Insurance Law. For service in the armed forces, insurer must also include a “suspension” provision complying with Sections 3216 (c)(13)(14) and Section 52.17 (a)(9).

5. If insurer chooses to place an exclusion or limitation on coverage for cosmetic surgery, must comply with Section 52.16 (c)(5) of Regulation 62.
6. If insurer chooses to place an exclusion or limitation on coverage for foot care, must comply with Section 52.16 (c)(6) of Regulation 62.
7. If insurer chooses to place an exclusion or limitation on coverage for care in connection with structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference must comply with Section 52.16 (c)(7) of Regulation 62.
8. If insurer chooses to place an exclusion or limitation on coverage for benefits provided by the government, benefits provided pursuant to certain laws, services provided by certain employees or family members or for services normally provided free of charge, must comply with Section 52.16 (c)(8) of Regulation 62.
9. If insurer chooses to place an exclusion or limitation on coverage for dental care or treatment, must comply with Section 52.16 (c)(9) of Regulation 62.
10. If insurer chooses to place an exclusion or limitation on coverage for eyeglasses, hearing aids, and exams for their prescription or fitting, must comply with Section 52.16 (c)(10) of Regulation 62.

11. If insurer chooses to place an exclusion or limitation on coverage for rest cures, custodial care and transportation, must comply with Section 52.16 (c)(11) of Regulation 62.
12. If insurer chooses to place an exclusion or limitation on coverage related to territorial restrictions, must comply with Section 52.16 (c)(12) of Regulation 62.

For Section 52.16 (c)(12) compliance, must provide coverage within the United States, its possessions and the countries of Canada and Mexico.

13. For compliance with Sections 52.16 (e)(2) and 52.2 (i) of Regulation 62, insurers should note that Regulation 62 recognizes only aviation and its related activities and participation as a professional in sports as extra-hazardous activities which can be initially underwritten. These extra-hazardous activities may be excluded from coverage by means of prominently disclosed waivers (see Section 52.16 (e)(2)) at coverage issuance or extra premium (“rate up”) may be charged for coverage of such extra-hazardous activities or standard coverage may be issued when an applicant indicates participation in such extra-hazardous activities or coverage may be declined based upon participation in such extra-hazardous activities. Sections 52.16 (e)(2) and 52.2 (i) do not recognize any other avocations, vocations or activities as extra hazardous. Therefore, the insurer may only issue standard coverage or decline coverage for applicants participating in avocations, vocations or activities other than those defined in Section 52.2(i).
14. Individual accident and health coverages, including hospital indemnity insurance, are not plans which can contain coordination of benefit provisions (Section 52.23 (e)(3)(i)). Insurers have the ability to financially underwrite for other coverage before issuance, and have statutory provisions (Sections 3216 (d)(2)(C), (D), (E) and (F)) for excess insurance situations after issuance.

*In general, the exclusionary or limiting language can be no less favorable than the various paragraphs of Section 52.16(c) of Regulation 62.

VIII. Regulatory Rules relating to the Content of Forms for Individual Insurance

1. If insurer reduces benefits due to an age limit attainment, including a benefit period reduction, such reduction must be referenced on the first page or specification page of the policy – Section 52.17 (a)(3) of Regulation 62.
2. If policy contains accident benefits, accident benefits cannot be predicated upon loss occurring through accidental means or violent and external means – Section 52.17 (a)(8) of Regulation 62.
3. Insurer must comply with Section 52.17 (a)(9) of Regulation 62 and Section 3216 (c)(13)(14) of the Insurance Law for insureds entitled to suspend coverage during periods of military service.
4. Insurer attaching any rider or endorsement which reduces or eliminates coverage after policy issuance shall provide for signed acceptance by the insured – Section 52.17 (a)(12) of Regulation 62. See also 52.16 (e)(2), however, for waivers issued as a condition of issuance, renewal or reinstatement.
5. Riders or endorsements providing a benefit for which a specific premium is charged shall show the premium on the application, rider or elsewhere in the form – Section 52.17 (a)(14) of Regulation 62.
6. Different maximum daily hospital benefits or durations of coverage contained in the same policy shall not be based on the type of room accommodation, but may be based on the level

- of care unit (such as intensive care or extended care) to which a covered person is assigned. – Section 52.17(a)(16)
7. In general, the form cannot require loss from accidental injury to commence within less than 30 days after the date of an accident – Section 52.17 (a)(26) of Regulation 62.
 8. In general, any form which the insurer may cancel or refuse to renew cannot require that the form be in force at the time loss commences if the accident occurred while the form was in force – Section 52.17 (a)(26) of Regulation 62.
 9. Forms based upon attained age shall include the applicable schedule of rates – Section 52.17 (a)(29) of Regulation 62.
 10. Hospital indemnity forms which contain accidental death and dismemberment (AD&D) benefits shall have the AD&D benefits payable if the loss occurs within 90 days from the date of the accident, irrespective of total disability - Section 52.17 (b)(1) of Regulation 62.
 11. Hospital indemnity forms which contain specific accident dismemberment benefits shall not have the specific accident dismemberment benefits payable in lieu of other benefits unless the specific benefit exceeds the other benefit – Section 52.17 (b)(3) of Regulation 62.
 12. Benefits for specific injury due to accident shall not be in lieu of any disability benefits paid under a hospital indemnity policy, unless the specific benefit exceeds the disability benefit – Section 52.17 (c)(1) of Regulation 62.
 13. No hospital indemnity form shall reduce benefits solely on the basis of the sex or marital status of the insured – Section 4224(b)(1) of Insurance Law.
 14. Disability benefits conditioned upon hospital confinement shall be considered hospital, medical or surgical expense benefits for purposes of renewability and eligibility under Section 3216 of the Insurance Law and any relevant regulations – Section 52.17 (c)(4) of Regulation 62.
 15. Surgical fee schedules shall provide benefits for various surgical procedures which bear a rational relationship and reasonable relativity to each other, based on the nature of the procedure. Schedules conforming to the relativities of the State of New York Certified Surgical Fee Schedule shall be deemed to meet the requirements of this paragraph. – 52.17(a)(17)
 16. Surgical schedules contained in the policy shall include a provision providing coverage for procedures not specifically listed in the schedules and not otherwise excluded by the policy, and benefits therefor shall be consistent with the benefits for comparable procedures. – 52.17(a)(18)
 17. Multiple surgical procedures performed during the same operative session and through the same incision shall be reimbursed in an amount not less than that stated in the schedule for the most expensive procedure then being performed. Multiple surgical procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than that stated in the schedule for the most expensive procedure being performed, and with regard to the less expensive procedures in an amount at least equal to 50% of the scheduled amount for these procedures, unless a different amount is specifically set forth in the State of New York Certified Surgical Fee Schedule. – 52.17(a)(19)
 18. Hospital indemnity policies meeting the definitions of Section 52.9 (accident hospital indemnity) or Section 52.10 (limited benefits health insurance) shall not be designated in any

- manner inconsistent with the applicable definition, or which would encourage misrepresentation of the actual coverages provided. – Section 52.17(a)(22)
19. Where permissible, unilateral modifications by an insurer to existing accident and health coverage shall be made in accordance with applicable laws upon at least 30 days prior written notice to the policyholder. – Section 52.17(a)(25)(i)
 20. Where a policyholder is contractually required to provide prior written notice to terminate coverage, the notice stated in number 19 just above must be provided to the policyholder no less than 14 days prior to the date by which the policyholder is required to provide notice to terminate coverage. – Section 52.17(a)(25)(iii)
 21. A family policy shall provide that adopted children and stepchildren dependent upon the insured be eligible for coverage on the same basis as natural children. – Section 52.17(a)(30)
 22. A family policy covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child’s adoption. – Section 52.17(a)(31)
 23. Insurers issuing accident and health policies which provide hospital or medical coverage on an indemnity basis to persons eligible for Medicare must provide to applicants for that indemnity coverage a Guide to Health Insurance for People with Medicare in accordance with Section 52.17(a)(32) of Regulation 62.
 24. A hospital indemnity policy delivered or issued for delivery in New York State to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy. The notice shall either be printed on or attached to the first page of the disclosure statement delivered to insureds to comply with Section 52.54 of Regulation 62 or to the first page of the policy delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language: “THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.” – Section 52.17(a)(33)(i)
 25. Where applicable, applications for hospital indemnity policies which are provided to persons eligible for Medicare shall disclose the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy. The applicable statement prescribed in 42 U.S.C. section 1395ss(d)(3)(D) shall be used. – Section 52.17(a)(33)(ii)

IX. Other Provisions

1. The definition of “hospital” as used in a hospital indemnity policy must be no less favorable than required by Section 52.2(m) of Regulation 62
2. Most hospital indemnity policies cover confinements in a hospital due to accident or sickness. The amount payable is unrelated to the expenses incurred, and an amount up to the fixed sum indemnity chosen by the insured is paid while hospital confined.

Some hospital indemnity insurers, in an attempt to broaden the narrow based coverage, will pay up to the fixed sum indemnity chosen by the insured (or a percentage of the fixed sum indemnity chosen by the insured) in settings other than a hospital. For example, some hospital indemnity insurers will pay for confinement for a skilled nursing home stay or for

confinement in facilities certified by government entities in relation to alcohol or substance abuse treatments. The insurer sometimes will pay in those other settings for a shorter period of time than in a hospital, and the insurer often defines which facilities meet insurer requirements for payment.

So long as the time period for payment, the amounts paid and the facility definitions are reasonable, the Department will approve such benefits as an attempt to broaden the narrow scope of coverage of hospital indemnity policies. – Section 3217(b)(5), 52.1(c) and 52.1(d)

3. Some hospital indemnity insurers, in an attempt to broaden the narrow based coverage, will pay additional benefits for non-disabling injuries or outpatient surgery due to accident or sickness as two examples.

The Department will approve such additional benefits as attempts to broaden the narrow based coverage. However, insurers are reminded that certain mandated coverages in Section 3216(i)(j) of the Insurance Law apply to expense incurred hospital, medical and/or surgical coverage. In addition, Section 3216(g)(1) of the Insurance Law and Section 360.2(c) of Regulation 145 (11 NYCRR 360) set parameters on what type of coverage may be considered as hospital indemnity or when coverage becomes hospital, medical or surgical expense incurred coverage subject to requirements of expense incurred coverages including federal requirements and open enrollment and community rating requirements. Section 3216(l) of the Insurance Law also sets parameters as to when an individual hospital indemnity policy may become comprehensive enough to trigger the benefits of Section 4322 of the Insurance Law.

Therefore, hospital indemnity insurers are reminded to structure additional benefits in a hospital indemnity policy so that the policy remains a supplemental policy to avoid triggering all of the requirements of hospital, medical and/or surgical expense incurred coverages.

4. Hospital indemnity insurers are reminded that the use of the concept or definition “Continuous hospital confinement” must be no less favorable than Section 52.2(f) of Regulation 62.
5. Individual hospital indemnity policies may provide family coverage according to the requisites of Section 3216(a)(3)(4), (c)(4)(A)(B)(C) of the Insurance Law and relevant regulations.
6. Section 52.17(c)(4) indicates when a conversion policy is required according to the requisites of Section 3216(c)(5) of the Insurance Law and when a benefit extension is required under Section 52.17(a)(15).
7. Section 52.16(c)(3) requires coverage of complications of pregnancy in a hospital indemnity policy.
8. Complications of pregnancy must be defined in a hospital indemnity policy in a manner no less favorable than Section 52.2(e) of Regulation 62 requires.
9. Form definitions of benefit periods or lengths of time for which benefits are paid under a hospital indemnity policy must be meaningful as used in a hospital indemnity policy, fair to

the consumer and fully disclosed in the form language - originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.10 of Regulation 62.

10. Waiting periods before benefits under hospital indemnity policies are paid must be meaningful as used in a hospital indemnity policy, fair to the consumer and fully disclosed in the form language - originates from Section 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.10 of Regulation 62.
11. Probationary periods or similar periods in a hospital indemnity policy must conform to Section 52.16(d) of Regulation 62.
12. Form definitions of “injuries”, “sickness”, “preexisting condition”, “first manifest”, “first diagnosed or treated” or similar terminology must be meaningful as used in a hospital indemnity form, fair to the consumer and fully disclosed in the form language – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d), 52.2(v) and 52.10 of Regulation 62.
13. Form definition of “mental disorders” must be meaningful as used in a hospital indemnity form, fair to the consumer, and fully disclosed in the form language – originates from Sections 3201 (c)(3), Sections 3217 (b), 4224 (b)(2) of the Insurance Law and Sections 52.1 (c), 52.1 (d) and 52.10 of Regulation 62.
14. Form definition of “physician” or any substitute terms cannot unduly limit access of the insured to hospital indemnity benefits under the form – originates from Sections 3201 (c)(3), 3217 (b) of the Insurance Law and Sections 52.1 (c), 52.1 (d) and 52.10 of Regulation 62.
15. Form provisions dealing with waiver of premium during period of disability resulting from injuries or sickness and confinements must be meaningful as used in a hospital indemnity form, fair to the consumer and fully disclosed in the form language – originates from Section 3201 (c)(3), 3217 (b) of the Insurance Law and Sections 52.1 (c), 52.1 (d), 52.10 and 52.16 (b) of Regulation 62.
16. Section 3216(d)(1)(K) is governed by “lead in” wording present in Section 3216(d). The “lead in” wording proscribes approval of language which would be less favorable in any respect to an insured than the wording in Section 3216(d)(1)(K). Section 3216(d)(1)(K) sets forth parameters to allow an insured to bring an action at law or equity in a hospital indemnity policy or any individual commercial accident and health insurance policy. Arbitration provisions set forth as a contractual right of an insurer generally preclude an insured from bringing an action at law or equity. Therefore, the Department is under a statutory constraint because arbitration provisions in a policy which preclude an insured from bringing an action at law or equity would be less favorable in many respects to an insured than the parameters set forth in Section 3216(d)(1)(K).

The Department addresses here its statutory inability to approve arbitration provisions in a hospital indemnity policy. The Department does not address in this product outline other reasonable and appropriate mechanisms which an insurer may be able to use in its ongoing relationship with an insured.

17. Form provisions which coordinate or integrate hospital indemnity policy benefits with benefits payable from other individual or group health or disability policies are not

approvable in New York State for use in individual hospital indemnity policy forms – Section 52.23 (e)(3)(i) of Regulation 62.

18. Insurers in the individual hospital indemnity insurance market are reminded of their obligations under Section 3228 of the Insurance Law.

19. Hospital indemnity insurers are referred to Section 52.26 of Regulation 62 regarding their obligations concerning form provisions relating to exclusion of Medicare benefits and coverage termination upon eligibility for Medicare by reason of age only. – Section 52.26

X. Applications

1. If more than one application will be used, objective criteria is required to avoid unfair discrimination under Section 4224(b)(1) of the Insurance Law. An example of unfair discrimination would be that, if two applications offer different levels of underwriting, two individuals would receive the same policy but undergo different levels of underwriting.

Insurers are reminded of their obligations under Section 4224(b)(1) as they pertain to the use of application forms with hospital indemnity insurance policies. Objective and rational criteria must be used by the insurer to avoid unfair discrimination if the insurer is using multiple application forms with a hospital indemnity insurance form so different applicants are subjected to different medical and financial underwriting in attempting to obtain coverage. When a submission is made of multiple application forms to be used with hospital indemnity insurance where the Department could reasonably inquire about such obligations, the insurer should provide a detailed and prominent explanation in the submission letter about the use of multiple application forms with a hospital indemnity insurance product.

2. Section 52.51(a) of Regulation 62 requires that an application cannot contain questions as to race of the applicant.
3. Section 52.51(b) of Regulation 62 requires that questions regarding past or present health of any person that refers to a specific disease or general health must be asked to the best of the applicant's knowledge and belief. Questions regarding factual information, such as doctor's visits or hospital confinements, do not require this qualification.
4. Section 52.51(c) of Regulation 62 requires that no application will contain a provision that changes the terms of the policy to which it is attached.
5. Section 52.51(d) of Regulation 62 requires that no application will contain a statement that the applicant has not withheld any information or concealed any facts.
6. Section 52.51(e) of Regulation 62 requires that no application will contain an agreement that an untrue or false answer material to the risk shall render the contract void.
7. Section 52.51(f) of Regulation 62 requires that no application will contain an agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except in conformity with Section 3204 of the Insurance Law.
8. Section 52.51(g) of Regulation 62 requires that applications for conversion policies may not contain questions as to the health of the person or persons entitled to conversion.

9. Section 52.51(h) of Regulation 62 requires that applications for policies subject to Section 3216(d)(2)(D) or (E), “Insurance with Other Insurers”, will contain a question or questions requiring information with respect to such other insurance.
10. Section 52.51(i) of Regulation 62 requires that if an insurer includes in a policy the optional standard provision under Section 3216(d)(2)(C), “Other Insurance in this Insurer”, a statement describing the provision in the policy must be included in the application, or provided at the time of application by separate notice.
11. Section 52.51(j) of Regulation 62 requires that if a policy contains a provision with respect to “pre-existing conditions”, a statement describing the policy provision must be included in the application OR provided at the time of application by delivery of the disclosure statement required by Section 52.54.
12. Previous HIV test results are NOT questioned, sought or used per Sections 3217(b) and 52.1 of Regulation 62. Information regarding the diagnosis or treatment of AIDS or ARC may be sought and used. Also, the insurer has the right to conduct its own medical tests as part of the underwriting process.
13. Individual hospital indemnity insurers are reminded of their obligations under Section 2611 of the Insurance Law and Section 2782 of the Public Health Law regarding written informed consent, authorization and disclosure of confidential information when the insurer uses an HIV antibody test in underwriting. Circular Letters No. 3 (1989) and No. 5 (1997) are relevant.
14. If the filing contains a reference to a telephone or in-person interview, the interview is conducted in the following manner:

Any questions raised during the interview are limited to those questions appearing on the application (i.e., questions over the phone would be no different than those being asked in the application).

The applicant will have an opportunity to review and make corrections to those statements that were attributed to him/her in the interview.

Any information obtained in the interview that will be used in the underwriting process will be reduced to writing, signed by the applicant and attached to the policy in compliance with Section 3204 of the Insurance Law.
15. If an Investigative Consumer Report will be prepared or procured, the insurer complies with Section 380-c of the General Business Law by providing notice in the application or in a separate form.
16. If a Medical Information Exchange Center (such as a Medical Information Bureau) will be used, the insurer complies with Section 321 of the Insurance Law.
17. Section 420.18(b) of Regulation 169 requires that an authorization to disclose nonpublic personal health information specifies the length of time the authorization will remain valid (maximum 24 months).
18. Section 403(d) of the Insurance Law requires a fraud warning on the application form.
19. Section 3204 of the Insurance Law contains requirements that apply to application forms for individual hospital indemnity insurance policies. An insurer may make insertions for administrative purposes only as long as the insertions are clearly not ascribed to the applicant. No other insertions or

alterations of a written application will be made by anyone other than the applicant without his written consent.

XI. Disclosure Requirements

1. Sections 52.54 and 52.59 of Regulation 62 set forth disclosure requirements which apply to individual hospital indemnity policies.

XII. Marketing of Individual Hospital Indemnity Insurance Using Group Methods

The individual hospital indemnity insurance checklist contains items pertaining to whether a filing is individual, "list bill" or franchise. The requirements for each category are listed in the checklist, and those requirements will not be repeated here. However, this individual hospital indemnity insurance product outline will explain the necessity of including these items on the individual hospital indemnity checklist.

These items are a recognition of how individual hospital indemnity insurance is generally sold in the New York State marketplace by insurers and their agents, brokers or other representatives. In the sale of individual accident and health insurance, including hospital indemnity insurance, it is generally recognized that individual sales on a "one to one" basis are the most time consuming and costly to administer. There is no ability to know beforehand the characteristics of the insureds who will purchase the individual product (as contrasted with true group coverage where, as an example, one knows the type of employer or association purchasing---e.g. coal miners vs. librarians). True individual sales only occur by individual solicitation where not many insureds are purchasing at a particular point of sale. The medical underwriting, if any, is generally detailed to obtain and process. Due to such factors, the minimum loss ratios in Regulation 62 for such coverage are generally lower than for group coverages or coverages where many sales are made at one time or where group characteristics are apparent. Similarly, the individual sale is usually an adhesion contract situation where the insurer retains most of the bargaining leverage at point of sale, and the insurer retains that superior bargaining position concerning various issues such as claim processing after individual coverage is in force. This situation aids in explaining why many of the Insurance Law provisions pertaining to individual accident and health coverages (such as standard provisions) are more detailed and protective of the individual insured. This same situation aids in explaining why many of the Regulation 62 provisions pertaining to individual accident and health coverage are also more detailed and protective of the individual insured.

Over the years, however, insurers have developed mechanisms in the individual accident and health insurance marketplace which are not solely individual sales. These mechanisms seek to market or offer the individual product using group or quasi-group type methods. Often, however, the insurer does not want to pass on all or some of the savings or advantages of marketing an individual product in a group or quasi-group type manner. Thus, insurance regulations become necessary to protect the consumer. In addition, even when the insurer seeks to pass on some of the savings or advantages, the group or quasi-group type arrangement is not present forever. Sometimes the individual product group-type sales arrangement does not meet statutory requirements in New York State. Statutory and regulatory requirements can determine whether the group or quasi-group type marketing methods for an individual product are appropriate, and how much of the advantage of those methods should be passed on to the insured and for how long. The integrity of the New York statute recognizing groups is important when considering the appropriateness of marketing or offering an individual product with group or quasi-group methods. The integrity of that statute is important so the public is not misled into believing an individual product (without all or some of the advantages of a group product) is a group product as recognized by law with the consequential advantages of a group product.

Based upon the foregoing, the individual hospital indemnity insurance checklist has set forth the mechanisms through which individual hospital indemnity insurance products can be marketed using group or quasi-group methods. The first method which is a step toward group or quasi-group methods is

a payroll deduction arrangement. When this arrangement is used for premium payments with no discounts at all and no other type of group or quasi-group methods, the individual hospital indemnity product remains subject to regulation as an individual product. No group or quasi-group savings or advantages to any significant degree are claimed by the insurer, and the individual insured has the convenience of payroll deduction as long as the employer is willing to provide that convenience. Here the insurer will accept premium payments directly from an insured should the insured lose the convenience of payroll deduction or choose not to use payroll deduction to pay premiums.

The second method which is the next step toward group or quasi-group methods is “list bill.” One will not find this method as a statutory or regulatory exception to the statute which recognizes permissible groups in New York State. It has been a method recognized by the Insurance Department as an accommodation to insurers for over 30 years.

Essentially, insurers desiring to use this method must differentiate it from franchise insurance (see below) to retain the exclusive treatment as an individual product, including but not limited to the generally lower individual minimum loss ratio more favorable to the insurer. The Insurance Department views this method as the sale of very few individual policies at a common site or address (usually an employer or some association) with no exclusivity granted to the insurer, no sponsorship by the employer or association, no mass marketing (i.e. - agent or representative engages in the “one on one” sale) and no contribution of premiums by the employer or association. The employer or association may remit or not remit premiums through the sending of a single bill to the common address of the employer or association where the few individual insureds work or have a membership. Generally, this situation goes further than the payroll deduction arrangement because there are a few sales at a small employer or association site, and the insurer provides actuarial justification to the Insurance Department that the “list bill” arrangement is worth some small discount.

The Department views the sale of very few individual policies as a “case by case” factually specific measurement. It should be clear in a “list bill” arrangement that the number of policies sold as a portion of the number of lives solicited is small. It should also be clear that the “list bill” arrangement is not being used as a substitute for franchise or group insurance especially to avoid the higher loss ratio requirements of franchise or group insurance. If the insurer or its agent were to obtain a disproportionate share of insureds as a portion of the number of lives solicited, there may be a likelihood that exclusivity, sponsorship, mass marketing and other indicia of franchise or group insurance are present. Generally, “list bill” arrangements are found at small employer or small association sites.

It is important to note that the “list bill” discount is dependent upon the factual circumstances noted here for its continued existence. Since the “list bill” arrangement as understood by the Insurance Department provides such marginal savings and advantages of a group or quasi-group nature and a rather small discount, the Insurance Department regulates the individual hospital indemnity insurance product as still an individual product with the generally more favorable individual minimum loss ratio. However, due to the marginal savings and advantages, the Insurance Department requires that the small discount revert to the higher individual premium if the “list bill” situation goes out of existence, and the insured continues to pay his/her premium on a direct bill basis. Once the “list bill” situation goes out of existence and the marginal savings and advantages also do not exist, the insured is a usual individual insured who should pay the undiscounted individual rate like other individual insureds to avoid “unfair discrimination” under Section 4224 (b)(1) of the Insurance Law. Prominent disclosure in the form of the increased rate when the “list bill” situation ends must occur.

The third method which is the last method and the most expansive method of marketing or offering individual hospital indemnity insurance products with group or quasi-group savings or advantages is franchise insurance. Sections 52.2 (k), 52.19 and 52.70 of Regulation 62 (11NYCRR52) should be consulted. Generally, individual hospital indemnity insurance products are distributed on a mass merchandising basis, administered by group methods and provided with or without evidence of insurability. Sponsorship by an employer or association occurs and exclusivity in the marketing of the

individual products is granted to a particular insurer. The individual contract mechanism is retained. So the legal relationship is directly between the insured and insurer with no group policy being issued to a group policyholder. However, the insurer is generally able to know beforehand the characteristics of the insureds (e.g. – bar association, medical society, etc.), and the insurer is generally able to obtain a significant number of insureds due to the sponsorship of the employer or association, exclusivity granted to the insurer in marketing the individual hospital indemnity insurance product and more sizeable discounts for the insured. We are just short of marketing the product as group under New York law, but the employer or association does not enter the direct legal relationship of the insurance contract and is not the group policyholder.

In the franchise situation, the agent or insurer representative usually does less work because of the sponsorship and exclusivity. The insurer achieves economies of acquisition and administration as well as knowing there is some affinity or relationship among all the insureds purchasing the franchise individual product. Therefore, the Insurance Department requires that these factors accrue to the insured's benefit in the regulation of the franchise individual product. A higher minimum loss ratio is required, and the insurer can allow the discount on the franchise product to remain if the franchise arrangement ends because of the sizeable savings and advantages occurring at point of sale which can be recognized over the lifetime of the franchise form. (These sizeable savings and advantages do not occur with the first two methods either resulting in no discount or the reversion to the higher individual rate. The Department will allow an insurer to charge the higher individual rate upon termination of the franchise arrangement for any reason if the insurer provides actuarial justification as to why the franchise savings and advantages do not warrant continuation of the discount upon termination of the franchise arrangement. In that instance, prominent disclosure of the higher rate in the form is necessary as with the "list bill" arrangement.)

XIII. Conditional Receipts/Interim Insurance Agreements

Section 52.53 of Regulation 62 requires that, if premium is paid prior to policy delivery and the insurer requires a determination of insurability as a condition precedent to the issuance of a policy, an insurer must issue either a conditional receipt or interim insurance agreement. In general, Section 52.53 sets forth two permissible methods for money to be accepted with an application – conditional receipt or interim insurance agreement. Section 52.53(c) defines a "determination of insurability" as a determination by the insurer as to whether the proposed insured is insurable under its underwriting rules and practices for the plan and amount of insurance applied for and at the insurer's standard premium rate.

1. A conditional receipt sets an effective date for the policy if the applicant successfully completes the underwriting process. The conditional receipt shall contain an agreement to provide coverage subject to any reasonable limit regarding the amount of insurance specified in the receipt, contingent upon insurability, and provides that such insurability be determined as of a date no later than:

The date of completion of all parts of the application, including completion of the first medical examination if one is required by the company's underwriting rules,
AND

The required premium has been paid.

Completion of a second medical examination may be required as a condition precedent to coverage if initially required by the company's underwriting rules because of the amount of insurance applied for or the age of the proposed insured.

If the proposed insured is insurable as of the above date, coverage under the issued policy begins not later than such date, except as provided in paragraph 4 below. Section 52.53(a) of Regulation 62.

2. Although the proposed insured dies, undergoes a change in health or otherwise becomes uninsurable according to the insurer's underwriting standards for the insurance plan for which application was made after the date provided in paragraph 1 above but before the application is approved or rejected

and before the expiration of any time limit specified in the receipt, an insurer may determine that the proposed insured is not insurable only as of the date stated in paragraph 1. Information relating to an event or physical condition that is the subject of a question in any part of the application cannot be considered for underwriting purposes if the event or accident occurred or sickness first manifested itself after completion of that part of the application. Adverse changes in insurer underwriting rules after the date stated in paragraph 1 cannot be taken into account when such adverse changes in underwriting rules take effect after the date stated in paragraph 1 but before the application is approved or rejected and before the expiration of any time limit specified in the receipt. (In summary, policy underwriting can only be based on the insured's health status as of the date provided for in paragraph 1.) Section 52.53(e) of Regulation 62.

Suppose a hospital indemnity applicant pays premium with his/her application, and the insurer issues a conditional receipt to the applicant on December 1, 2002. The applicant completes all parts of the application truthfully on December 1, 2002, and the applicant awaits the insurer's underwriting decision. Then assume on December 15, 2002 (which is before the expiration of a 60 day time limit in the receipt), the applicant is diagnosed with a severe condition causing confinement which would be covered under the hospital indemnity policy applied for (but not yet issued because the insurer is in the process of underwriting). The applicant begins to incur covered loss on December 15, 2002. Then assume the applicant dies on January 27, 2003. The insurer would be using its underwriting rules in effect on December 1, 2002, and the insurer would be assessing the insured's health as of December 1, 2002 based upon a truthful application submitted by the applicant on December 1, 2002. The insurer would issue a hospital indemnity policy dated effective December 1, 2002. If the hospital indemnity policy issued had a 0-day waiting period for covered loss, the insurer would be obligated to pay for covered loss according to policy terms from December 15, 2002 until January 27, 2003. This might all occur retrospectively if the insurer used the full 60 day period mentioned in the conditional receipt and did not issue the hospital indemnity policy with a December 1, 2002 effective date until January 29, 2003.

3. An interim insurance agreement provides some type of immediate limited insurance coverage as of the application date. The agreement provides coverage in accordance with the policy and plan of insurance described in the application subject to any reasonable limit regarding the amount or duration of insurance specified in the agreement. Coverage is provided as of the application date and must provide at least 60 days coverage unless:

The policy applied for is issued prior to the end of the 60 days, OR

The applicant receives actual notice that coverage under the agreement is cancelled because the application has been declined. If notice is given by mail, it may be deemed received on the fifth day after mailing such notice to the applicant. Section 52.53(b) of Regulation 62.

4. An insurer may honor a written request from the applicant that coverage begins as of a specified date later than the date provided for in the conditional receipt or interim insurance agreement. In other than replacement situations, the applicant's written request for a later effective date must contain a statement signed by the applicant that he/she understands that he/she may be waiving certain rights and guarantees under the conditional receipt or interim insurance agreement. Section 52.53(f) of Regulation 62.
5. If coverage is provided under a conditional receipt or interim insurance agreement for two or more proposed insureds, the coverage must be determined separately for each proposed insured, except, however, all proposed insureds may be rejected in the event of fraud or material misrepresentations. Section 52.53(d) of Regulation 62.

6. If a policy is not issued within the time specified in the conditional receipt or interim insurance agreement, the application will be deemed rejected and all premiums will be refunded. Section 52.53(i) of Regulation 62.
7. In mail order cases only, an insurer may postpone the effective date of coverage to the date of issuance of the policy. Section 52.53(g) of Regulation 62.
8. In franchise cases, the coverage under the conditional receipt or interim insurance agreement may be made contingent upon meeting specified participation requirements. Section 52.53(h) of Regulation 62.

The Department will entertain reasonable alternatives to Section 52.53 requirements, but any alternative must be as favorable for an insured as Section 52.53 requirements. The insurer cannot take the most favorable aspects of a conditional receipt and interim insurance agreement for an insurer and submit a hybrid form that is not as favorable for an insured as under Section 52.53.

XIV. Rating Procedures and Requirements

1. Section 52.40 (a) of Regulation 62 sets forth general procedures and requirements which apply to the rating of hospital indemnity forms.
2. Section 52.40 (b) of Regulation 62 sets forth prohibited rating practices which may be applicable to hospital indemnity forms.
3. Section 52.40 (c) of Regulation 62 sets forth requirements applicable to individual hospital indemnity forms.
4. Section 52.40 (d) of Regulation 62 sets forth requirements applicable to individual hospital indemnity forms.
5. Section 52.41 of Regulation 62 sets forth gross premium differentials based on sex which apply to individual hospital indemnity forms.
6. Section 52.43(a) of Regulation 62 sets forth standards for maintaining experience data which apply to individual hospital indemnity forms.
7. Section 52.44 (a)(b) of Regulation 62 sets forth monitoring standards which apply to individual hospital indemnity forms.
8. Section 52.45(a), (b), (c), (d) and (e) of Regulation 62 sets forth minimum loss ratio standards which apply to individual hospital indemnity forms.
9. Section 52.40(i) of Regulation 62 sets forth rules for franchise insurance rates.