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

Instructions for SERFF Checklist

A. For **ALL** filings, the "General Requirements for All Filings" section in this checklist MUST be completed.

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

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

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

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

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

LINE OF BUSINESS:	Disability Income Insurance	LINE(S) OF INSURANCE	CODES
CODE:	H11I	Short Term Long Term	H11I.002 H11I.003

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

		Note: SERFF filing descriptions should advise as to whether the policy is intended for internet sales..	
Form Requirements	§ 3201(c) § 3217(b) 11 NYCRR 52.1(c) 11 NYCRR 52.31	Each form in the filing must meet the following requirements: • The form provisions are NOT misleading or unreasonably confusing. § 3217(b)(2), § 52.1(c) • The form provisions provide substantial economic value to the policyholder. § 3217(b)(5), § 52.1(c) • The form provisions NOT unjust, unfair, inequitable, misleading, or deceptive to the policyholder. §§ 3201(c)(3), 3217(b) • The form contains no strikeouts. § 52.31(b) • The form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. § 52.31(d) • The form is submitted in the form intended for actual use. § 52.31(e) • All blank spaces are filled in with hypothetical data. § 52.31(f) • If the form contains illustrative material, it is only used for items which may vary from case to case, such as names, dates, eligibility requirements, and premiums and schedules for determining the amount of insurance for each insured person. A full explanation of the nature and scope of the variable material, contained in an Explanation or Memorandum of Variable Material, should be uploaded to the Supporting Documentation tab in SERFF. § 52.31(l) • If the form is available to spouses or dependents, **select only one**: ☐ The spouse/dependent receives their own individually issued policy; OR ☐ The spouse/dependent is covered under the one policy issued to the primary insured.	
Flesch Score	§ 3102(c)	Provide Flesch score certification (the Flesch score should be at least 45). The number of words, sentences and syllables in the policy form should be set forth as part of the certification, which must be signed by an officer of the company.	
Fraternal Benefit Society	§ 4501(p) § 4504(g) § 4512(a) § 4527(b) 11 NYCRR 49.1	If the insurer is a Fraternal Benefit Society, the policy includes a provision that states that if its reserves as to any class of certificates, other than those portions of any certificate that provide variable benefits based on the experience of a separate account, become impaired, its board of directors may require that there shall be paid by the member to the society the amount of the member's equitable proportion of such deficiency as ascertained by its board. If the payment is not made it shall stand as an indebtedness against the certificate and draw interest not to exceed five percent per annum compounded annually, or the equivalent effective rate of interest if payable in advance, or in lieu thereof, or in combination therewith, the member may consent to a reduction of the corresponding insurance benefit proportionate to the value of the additional contributions. The maximum accident disability benefits may not exceed $1,250 a month.	
Individual Insurance Type	§ 3216 11 NYCRR 52.2(k) 11 NYCRR 52.19 11 NYCRR 52.70	Select only one of the types of insurance listed below: ☐ **INDIVIDUAL**. Insurance qualifies as Individual coverage when it meets the following requirements: • NO premium discount for the policy for group or quasi-group market methods. *Note: An individual filing may have a premium discount for factors such as spousal/domestic partner status, preferred risk, etc.*; • Individual minimum loss ratio; • Available to any individual in the general public;	

		• No exclusivity granted to the insurer by the employer or association if sold at a worksite; • No sponsorship; • No mass marketing; • Regular sales method on a one-to-one basis; • No employer or association contributions toward premium; and • Insurer may have a premium remittance agreement with an employer or association that is willing to participate in a payroll deduction arrangement, but the agreement is irrelevant to how the coverage is being sold. ☐ **LIST BILL**. Insurance qualifies as List Bill coverage when it meets the following requirements: • Very few of the individual policies are sold at a common site or address (employer or association); • No exclusivity granted to the insurer by the employer or association; • No mass marketing; • No employer or association funds are contributed toward premium, but employer or association does/does not remit insured's premium payment. The individual policyholder pays the entire premium; • When the "list bill" arrangement ceases for any reason, the premium discount for "list bill," if any, increases to the regular individual rate. The increase in rate upon cessation of the arrangement is disclosed prominently on the cover page of the policy or the policy schedule AND in the application; and • The premium discount for "list bill," if any, is no greater than 10%. ☐ **FRANCHISE**. Insurance qualifies as Franchise coverage when it meets the following requirements: • Franchise definition per 11 NYCRR 52.2(k); • All form content requirements for franchise per 11 NYCRR 52.19; • Class and participation requirements per 11 NYCRR 52.70(b) and (c); and • Policy states whether rates will increase when franchise relationship ends. If the rates will increase, the increase in rate upon cessation of the arrangement is disclosed prominently on the cover page of policy or the policy schedule AND in the application.	
Rider or Endorsement	11 NYCRR 52.16(e)(2) 11 NYCRR 52.17 (a)(5), (6), (12), (14) 11 NYCRR 52.31(a)	If the rider or endorsement provides a benefit for which a specific premium is charged, the premium is shown on the application, rider or elsewhere in the policy. § 52.17(a)(14) If the rider or endorsement will be issued with an existing "guaranteed renewable" policy, such rider will be made available at the option of the insured. §§ 52.17(a)(5), (6) If the rider or endorsement reduces or eliminates coverage after policy issuance, it provides for signed acceptance by the insured. § 52.17(a)(12) New policy forms must comply with any statutory requirements without the use of amendatory riders or endorsements except for minor changes, where minor changes are necessitated by distinctive New York requirements. Previously approved policies may have a rider(s) attached to	

		comply with changes in New York law, but only if the rider(s) does not cause the policy in its entirety to mislead or confuse the policyholder. § 52.31(a) *Note: For waivers issued as a condition of insurance, renewal or reinstatement, see 11 NYCRR 52.16(e)(2).*	
Table of Contents	§ 3102(c)(1)(G)	A table of contents is required for policies that are over 3,000 words or more than three pages regardless of the number of words.	
Vending Machine	11 NYCRR 52.17(b)(2)	If the policy form will be sold by a vending machine, the insurer must attach information and the directions used in connection with the vending machine.	
APPLICATION FORMS			Form & Page Number
Authorization	11 NYCRR 420.18 Circular Letter No. 8 (2017) 42 USC § 290dd-2 42 CFR § 2.31	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months. A written authorization that consents to a disclosure of substance use disorder records must include: (1) the specific name or general designation of the program or person permitted to make the disclosure; (2) the name or title of the individual or the name of the organization to which disclosure is to be made; (3) the name of the patient; (4) the purpose of the disclosure; (5) how much and what kind of information is to be disclosed; (6) the signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under 42 C.F.R. § 2.14 or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under 42 C.F.R. § 2.15 on behalf of the patient; (7) the date on which the consent is signed; (8) a statement that the consent is subject to revocation at any time except to the extent that the program or person that is to make the disclosure has already acted in reliance on it, where acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; and (9) the date, event or condition upon which the consent will expire if not revoked before that date, event or condition.	
Discrimination	§ 2606 § 2607 § 2608 § 2612 Circular Letter No. 3 (2016)	No insurer or entity shall refuse to issue any insurance policy, or cancel or decline to renew the policy or otherwise unfairly discriminate because of race, color, creed, national origin, disability, sex, and marital status, or engage in sexual stereotyping. "Sex" includes sexual orientation, gender identity or expression and transgender status. No insurer or entity shall refuse to issue or renew, or shall cancel any insurance policy because of any past treatment for a mental disability of the insured. With respect to past treatment for a mental disability, an issuer may refuse to issue, renew, or cancel a policy if the issuer relies on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience.	
Electronic Application	§ 3201(c)(1) 11 NYCRR 52.1(c) State Technology Law Article III 9 NYCRR Part 540	If an insurer is seeking approval to use a previously approved paper application in electronic format, screen shots of the previously approved paper application must be filed for reference for informational purposes. Any drop downs, pop-ups, FAQs, or linked material that could appear in the application process must be included either within the screen shots or as a supporting document provided for informational purposes. If an insurer is seeking approval of an application not previously approved that will only be available in an electronic format (i.e., will be completed and signed electronically) and there is no corresponding paper application, then screen shots must be submitted for approval as the application	

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

Fraternal Benefit Society	§ 4501(a) § 4505 § 4512	If the insurer is a fraternal benefit society, the application asks if the applicant is a member and, if the applicant is not a member, the application requires the person to apply for membership.	
Fraud Warning Statement	§ 403(d) 11 NYCRR 86.4(a), (d)	All application form contains the prescribed fraud warning statement listed below. The fraud warning statement must be placed directly above the signature line and printed in such a way that it is conspicuous to the insured such as by using bold font or larger font size. "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."	
Future Activities	11 NYCRR 52.1(c)	Applications should not inquire about open ended future activities or the future intent of the applicant (such as asking if the insured ever plans on leaving the country) as these are unduly speculative. Questions should be limited to present intent or present plans.	
Health Questions	11 NYCRR 52.51(b)	Any question of past or present health of any person that refers to a specific disease or general health must be asked "to the best of the applicant's knowledge and belief." This does not apply to questions about factual information such as doctor visits or hospital confinements. *Note: The application should phrase each question with respect to this statement; or, in the alternative, a sentence that states that "the following questions are asked to the best of the applicant's knowledge and belief." may be added to the beginning of any application section that includes questions regarding a specific disease or general health.*	
Insurance with Other Insurers	§ 3216(d)(2)(D) § 3216(d)(2)(E) 11 NYCRR 52.51(h)	If the application is used with a policy subject to Insurance Law §§ 3216(d)(2)(D) or 3216(d)(2)(E), "Insurance with Other Insurers," the application contains a question requiring information with respect to other insurance.	
Investigative Consumer Report	General Business Law § 380-c	If an Investigative Consumer Report will be prepared or procured, a notice and authorization complying with General Business Law § 380-c is included in the application OR in a separate form.	
Medical Information Exchange Center	§ 321	If the insurer will transmit medical information from an applicant for personal insurance to a Medical Information Exchange Center (such as a Medical Information Bureau) or other similar facility, the insurer must provide a clear and conspicuous notice disclosing: • A description of the Medical Information Exchange Center or other facility and is operations, including its name, address and telephone number where it may be contacted to request disclosure of any medical information transmitted to it; • The circumstances under which the Medical Information Exchange Center or other facility may release such medical information to other persons; and • Such applicant's right to request the Medical Information Exchange Center or other facility to arrange disclosure of the nature and substance of any information in its files pertaining to them, and to seek correction of any inaccuracies or incompleteness of such information.	
Multiple Levels of Applications and/or Underwriting	§ 4224(b)	If more than one level of medical and financial underwriting (e.g., full underwriting, simplified underwriting, or guaranteed issue) is used for a policy, or multiple applications are used, attach a full explanation of: • The various levels of underwriting; and • The objective criteria used to determine the use of each level of underwriting.	

Other Insurance in This Insurer	§ 3216(d)(2)(C) 11 NYCRR 52.51(i)	If the application is used with a policy that includes the optional standard provision "Other Insurance in This Insurer," the application contains a statement describing the provision in the policy OR, if provided at the time of application by separate notice, the notice is included in this filing.	
Pre-Existing Conditions	11 NYCRR 52.51(j) 11 NYCRR 52.54	If the application is used with a policy that contains a "pre-existing conditions" provision, a statement describing the policy provision is included in the application OR the statement is included in the disclosure statement required by 11 NYCRR 52.54 that is delivered at the time of application.	
Prohibited Questions and Provisions	§ 3204 11 NYCRR 52.51	The application does NOT contain: • Questions regarding the applicant's race; • A provision that changes the terms of the policy to which it is attached; • A statement that the application has not withheld any information or concealed any facts; • An agreement that any untrue or false answer material to the risk will render the policy void; • An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and insured in the application, except to conform to Insurance Law § 3204(d); and • Questions regarding HIV, such as HIV testing, test results, or treatment. *Note: Information regarding the diagnosis or treatment of AIDS may be sought and used. The insurer has the right to review medical records or conduct its own medical tests as part of the underwriting process. References to AIDS Related Complex (ARC) should no longer be used as the terminology has been discontinued in the medical community.*	
Representations not Warranties	§ 3105 § 3204(c), (d)	Statements made on the application by the applicant are representations and not warranties, and only material misrepresentations can avoid a contract of insurance. No representation is deemed material unless knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to issue the policy. *Note: The insurer may make insertions to the application only for administrative purposes 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 the applicant's written consent pursuant to Insurance Law § 3204(d).*	
Telephone or In-Person Interview	§ 3204 State Technology Law Article III	If a telephone or in-person interview will be used with this application, the interview is conducted in the following manner: • Any questions raised during the interview are limited to those questions appearing on an application approved by the Department (i.e., questions over the phone would be no different than those being asked in the application); • The applicant must be provided with a written copy and will have an opportunity to review and make corrections to those statements that were attributed to him/her in the interview; • Any information obtained in the interview that will be used in the underwriting process will be reduced to writing, signed by the applicant and attached to the policy in compliance with Insurance Law § 3204; • If an electronic signature is used, it must comply with the Electronic Signatures and Records Act (State Technology Law Article III); and • If a telephonic application is being used, please provide a description of the procedure for taking a telephonic application. Any scripts used in the telephone interview must be filed for reference.	

Written Informed Consent for HIV Testing	§ 2611 Public Health Law § 2782 Circular Letter 3 (1989) Circular Letter 5 (1997)	No insurer or its designee shall request or require an applicant for insurance coverage to be the subject of an HIV related test without receiving the written informed consent of such individual prior to such testing and without providing general information about AIDS and the transmission of HIV infection. Written informed consent to an HIV related test shall consist of a written authorization that is dated and includes at least the following: • a general description of the test; • a statement of the purpose of the test; • a statement that a positive test result is an indication that the individual may develop AIDS and may wish to consider further independent testing; • a statement that the individual may identify on the authorization form the person to whom the specific test results may be disclosed in the event of an adverse underwriting decision, which person may be the individual or a physician or other designee at the discretion of the individual proposed for insurance; • the Department of Health's statewide toll-free telephone number that may be called for further information about AIDS, the meaning of HIV related test results, and the availability and location of HIV related counseling services; and • the signature of the applicant for insurance, or if such individual lacks capacity to consent, the signature of such other person authorized to consent for such individual. *Note: In addition to compliance with the written informed consent under Insurance Law § 2611, the insurer has obligations under Public Health Law § 2782 regarding written informed consent, authorization and disclosure of confidential information regarding HIV testing.*	
CONDITIONAL RECEIPT/INTERIM INSURANCE AGREEMENT FORM			
Advance Premium	11 NYCRR 52.53	An insurer must issue either a conditional receipt or interim insurance agreement if premium is paid prior to delivery of the policy and the insurer requires a determination of insurability as a condition precedent to the issuance of a policy. A conditional receipt which requires a determination of insurability as a condition precedent to coverage shall include an agreement to provide: coverage subject to any reasonable limit regarding the amount of insurance specified in the receipt, contingent upon insurability; and 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 insurer'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 insurer's underwriting rules because of the amount of insurance applied for or the age of the proposed insured. An interim insurance agreement which provides immediate coverage shall include an agreement to provide: coverage in accordance with the policy of insurance described in the application subject to any reasonable limit regarding the amount or duration of insurance specified in the agreement; and coverage as of the date of application. The period of coverage must be at least 60 days unless the policy applied for is issued prior to such date 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.	
Reinstatement	§ 3216(d)(1)(D)	If the insurer requires an application for reinstatement and issues a conditional receipt for the premium received, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application.	
POLICY FORMS			Form & Page Number
COVER PAGE			
Disclosure Statement	§ 3201(c)(3) § 3217(b)(5) 11 NYCRR 52.1(c) 11 NYCRR 52.54(a) 11 NYCRR 52.60	The following statement shall appear prominently in boldface type, in at least 14-point size but not less than the size of the type used for policy captions on the first page of the policy: This policy provides disability income insurance. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.	
Free Look	§ 3216(c)(10)	The cover page contains a "free look" provision that is prominently printed on it that states that during a specified period of time, which shall not be less than 10 days nor more than 20 days from the date the policy is delivered to the policyholder, it may be surrendered to the insurer together with a written request for cancellation of the policy and in such event the insurer will refund any premium paid therefor including any policy fees or other charges, provided, however, that this paragraph shall not apply to single premium nonrenewable policies insuring against accidents only or accidental bodily injuries only; provided, however, that a contract or certificate sold by mail order must contain a provision permitting the contract or certificate holder a 30 day period for such surrender. *Note: This provision is NOT required for single premium nonrenewable policies insuring against accidents only or accidental bodily injuries only.*	
Label	11 NYCRR 52.8	The policy form is labeled as "Disability Income Insurance" within the definition of 11 NYCRR 52.8.	
Insurer Name		The policy form contains the name and full address of the New York-licensed issuer insurer on the front or back cover.	
Participating Policy	§ 3216(c)(1)	If the policy is participating (pays dividends to the policyholder), such is stated on the cover page OR schedule page.	
Reduction of Benefits or Benefit Period	11 NYCRR 52.17(a)(3)	If the policy form reduces benefits due to attainment of an age, any reduction in benefits because of the attainment of an age limit shall have a reference to such reduction set forth on the cover page or schedule of benefits. For purposes of this requirement, a reduction in a benefit period is a reduction in benefits requiring such reference.	
Renewability	§ 3216(c)(11) 11 NYCRR 52.17(a)(1),(2), (5)-(7)	The cover page of the policy form indicates whether the policy is renewable or nonrenewable and contains the renewability provision OR briefly describes and references the policy renewability provision. If the policy is guaranteed renewable, the insured has the right to continue in force by the timely payment of premiums until age 65 or, as an alternative with respect to policies defined in section 52.8 of this Part, until receipt of retirement benefits under the Social Security Act of the United States. During such period the insurer has no right to make unilaterally any change in any provision	

		of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes. If the policy is "non-cancellable" or "non-cancellable and guaranteed renewable," the insured has the right to continue in force by the timely payment of premiums set forth in the policy until age 65 or, as an alternative with respect to policies defined in section 52.8 of this Part, until receipt of retirement benefits under the Social Security Act of the United States. During such period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force. The words "guaranteed renewable" shall not be used in a policy form unless the insurer's right to change rates is also stated in such a way that it is not minimized or made obscure. If the policy form contains an age limit, date, or period after which the coverage will not be effective or renewed, the age limit, date, or period after which coverage will not be effective or renewed must be stated on the cover page in either the renewability provision, a separate provision with an appropriate caption, or a brief description in at least 14-point bold type.	
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy form (such as on the cover page).	
DEFINITIONS			
Complications of Pregnancy	11 NYCRR 52.2(e)	Complications of pregnancy is defined as conditions requiring hospital stays (when the pregnancy is not terminated) whose diagnosis is distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. Complications of pregnancy also includes nonelective caesarean section, ectopic pregnancy, which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.	
Health Care Professional to Diagnose or Treat the Insured, including Definition of Physician	§ 3201(c)(3) § 3217(b) 11 NYCRR 52.1(c) 11 NYCRR 52.1(d) 11 NYCRR 52.9	The policy form may define a licensed health care professional as an individual acting within the scope of his or her license that typically diagnoses or treats the insured's condition. If used, the policy form should define a "physician" as a licensed health care professional who diagnoses, treats, operates, or prescribes for any human disease, pain, injury, deformity, or physical condition. A licensed physician has completed a program of medical education and received the doctor of medicine (M.D.), doctor of osteopathic medicine (D.O.), or equivalent degree. The policy form may require that the insured be diagnosed with a disability by a physician, although for disabilities due to mental health or substance use disorders, the policy form should permit the insured to be diagnosed by another licensed health care professionals able to diagnose mental health or substance use disorders within the scope of their practice. Note: Policy forms should not unduly limit the insured's access to benefits by requiring that the insured seek care from a physician (meaning an MD or DO) when other licensed health care professionals may diagnose or treat the insured within the scope of their practice.	

Hospital	11 NYCRR 52.2(m)	Hospital" means a short-term, acute, general hospital, that: • is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons; • has organized departments of medicine and major surgery; • has a requirement that every patient must be under the care of a physician or dentist; • provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.); • if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 USC § 1395x(k); • is duly licensed by the agency responsible for licensing such hospitals; and is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitory care.	
Pre-Existing Condition	11 NYCRR 52.2(v)	A "Pre-Existing Condition" is defined 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 the coverage of the insured person, 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 for the insured person.	
ELIGIBILITY			
Adopted Children and Step-Children	11 NYCRR 52.17(a)(30) 11 NYCRR 52.1(a)(31)	If family coverage is selected by the policyholder, the policy form provides that adopted children and stepchildren dependent upon the insured are eligible for coverage on the same basis as natural children. Further, a family policy covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child is eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	
Children	§ 3216(a)(3) § 3216(a)(4)	If family coverage is selected by the policyholder, the policy form provides coverage of dependent children, which shall not exceed age 19, except that any unmarried student at an accredited institution of learning may be considered a dependent child until attaining age 23.	
Dependents	§ 3216(a)(3) § 3216(c)(3) 11 NYCRR 52.17(a)(10)	If family coverage is selected by the policyholder, family includes the policyholder's spouse, or dependent children, or any other person dependent upon the policyholder. This policy form must only cover one individual, or members of the insured's family either originally by application or upon subsequent amendment. If the policy form provides a new contestable period for each new family member added, the policy form must NOT provide a new contestable period for the policy.	
Domestic Partners	§ 3216(a)(3) OGC Op No. 01-11-23	If family coverage is selected by the policyholder, this policy form may provide coverage for domestic partners. In order to qualify as domestic partners, the insured must demonstrate proof of mutual economic interdependence evidenced as follows: 1. Registration as a domestic partnership in jurisdictions that have such registration; or 2. If no registration is available, then: a. An alternate affidavit of domestic partnership is required. The affidavit must be notarized and must contain the following: i. The partners are both 18 years of age or older and are mentally competent to consent to contract;	

		ii. The partners are not related by blood in a manner that would bar marriage under laws of the State of New York; iii. The partners have been living together on a continuous basis prior to the date of the application; and iv. Neither individual has been registered as a member of another domestic partnership for at least the last six (6) months; b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and c. Proof that the partners are financially interdependent by submission of two (2) or more of the following: a joint bank account; joint credit card or charge card; joint obligation on a loan; status as an authorized signatory on the partner's bank account, credit card or charge card; joint ownership of holdings or investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on the lease of the shared residence; shared rental payments of residence (need not be shared 50/50); listing of both partners as tenants on a lease, or shared rental payments, for property other than residence; a common household and shared household expenses (need not be shared 50/50); shared household budget for purposes of receiving government benefits; status of one as representative payee for the other's government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses (need not be shared 50/50); execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy; designation as beneficiary under the other's retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; or other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.	
Newborn Infants	§ 3216(c)(4)(C)	If family coverage is selected by the policyholder, the policy form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to Domestic Relations Law § 115-c within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. *Note: In the case of individual coverage, the insurer must permit the insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of birth to make coverage effective from the moment of birth.*	
Spouse	§ 3216(a)(4) Circular Letter No. 27 (2008)	If family coverage is selected by the policyholder, the policy form provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes the recognition of marriages between same-sex partners legally performed in New York and other jurisdictions.	
Unmarried Disabled Children	§ 3216(c)(4)(A)	If family coverage is selected by the policyholder, the policy provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of	

		mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. *Note: Such coverage shall not terminate while the policy remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.*	
Unmarried Students on Medical Leave of Absence	§ 3237	If the policy provides coverage for dependent children who are full-time students to a higher age than other dependent children, then coverage shall continue when such dependent takes a medical leave of absence from school due to illness for a period of 12 months from the last day of attendance at school, provided, however, that coverage of a dependent student is not required beyond the age at which coverage would otherwise terminate. To qualify for such coverage, the insurer may require that the medical necessity of the leave be certified to by the student's attending physician who is licensed to practice in the state of New York.	
DISABILITY INCOME INSURANCE STANDARD PROVISIONS			
Accident Benefits	§ 3216 11 NYCRR 52.8 11 NYCRR 52.17(a)(8), (15), (26) 11 NYCRR 52.17(b)(1), (3) 11 NYCRR 52.17(c)(1), (4), (5)	If the form contains benefits due to an accident in addition to a disability: • Accident benefits are NOT predicated upon loss occurring through violent and external means. Under this provision, the policy may not exclude benefits relating to a loss associated with terrorism. • Benefits for a specific injury due to accident are NOT payable in lieu of disability benefits unless the specific benefit exceeds the disability benefit. • Accidental death and dismemberment benefits are payable if the loss occurs a minimum of 90 days from the date of the accident, irrespective of total disability. *Note: Benefits for follow-up care that are based upon the occurrence of a loss (e.g., rehabilitation benefits) should provide the insured with adequate time to access the benefit. For instance, to require treatment under a rehabilitation benefit to be completed within 90 days of the covered accident may be illusory given the timing associated with entering a rehabilitation program following an accident.* • If the insurer may cancel or refuse to renew the policy, the policy form cannot require that the policy be in force at the time the loss commences if the accident occurred while the policy was in force.	
Definition of Disability	11 NYCRR 52.8 11 NYCRR 52.17(c)(5)	The policy form should clearly state the definition of a disability. For example, a policy form may define disability as when an insured is unable to perform his/her "own occupation" or "any occupation." Policies providing disability benefits for dependents shall adequately define the conditions establishing disability.	
Disability Benefit Amount	11 NYCRR 52.1(c) 11 NYCRR 52.8	The policy form provides for a benefit to replace the insured's income due to the insured's inability to work because of a disability. The benefit may replace up to 80% of the insured's income. If the	

		disability benefit exceeds 80% of the insured's pre-disability income, a justification should be submitted with the filing, explaining why the benefit is necessary.	
Disability Benefits Conditioned upon Hospital Confinement	11 NYCRR 52.17(c)(4)	If disability benefits are conditioned upon hospital confinement, it shall be considered hospital, surgical or medical benefits for purpose of Insurance Law § 3216(c)(5) and any relevant regulations.	
Occupational/Work-Related Disabilities	11 NYCRR 52.16(c) 11 NYCRR 52.16(c)(8)	The policy form must not distinguish between occupational (work-related or "on-the-job") or non-occupational coverage, or limit, reduce or exclude coverage for either occupational or non-occupational disabilities. To cover only occupational or non-occupational injuries excludes all other types of disabilities in violation of 11 NYCRR 52.16(c). *Note: An exclusion is available for benefits provided* under any state or federal *workers' compensation law. § 52.16(c)(8)*	
Reduction of Benefits	11 NYCRR 52.17(c)(3)	No policy shall provide for reduction of benefits prior to age 65 by reason of a change in employment status or the income of the insured, except in accordance with the optional standard provision entitled "change of occupation" or "relation of earnings to insurance" of Insurance Law § 3216, whichever is applicable, and no reduction of benefits shall be made applicable solely on the basis of the sex or marital status of the insured.	
OTHER INCIDENTAL BENEFITS IN A DISABILITY INSURANCE POLICY	§ 3201(c)(3) § 3217(b)(5) 11 NYCRR 52.1(c) Circular Letter No. 18 (2017)	If this policy form provides benefits in addition or incidental to those under 11 NYCRR 52.8, any such benefits should have a nexus to disability income insurance. All benefits must be of real economic value and may not be designed to play upon one's fears of particular diseases. Disability income insurance policies which are unduly complex or unduly limited do not meaningfully expand consumer choice, but instead serve to confuse and make intelligent choice more difficult. Those coverages which are of no substantial economic benefit or are contrary to the health care needs of the public or contain provisions which serve only to confuse or obfuscate are prohibited under 11 NYCRR 52.1(c). Benefits must be reasonable in relation to the premium charged. *Note: The following are several examples of benefits that have been approved in the past. This list is not meant to be exhaustive.*	
Cost of Living Adjustment (COLA or Inflation Benefit)		Provides an increase in the monthly benefit after the insured has been continuously disabled for a specified waiting period.	
Education Benefit (Child Education, Spousal Retraining)		This benefit defrays the cost of any education for a child or spouse while the insured cannot work.	
Family Care Benefit (Child Care, Parental Care)		This benefit pays for the dependent care of a child or family member while the insured's disability prevents him/her from caring for, or paying for care for, the individual.	
Home Alteration/Vehicle Modification Benefit		This benefit provides an additional benefit to the insured to be used to modify the insured's home or vehicle to allow the insured to use the home or vehicle despite their disability. This benefit is approvable if the following requirements are included: • A physician certifies the benefit is needed to accommodate a physical disability; • The alteration/modification is made by someone experienced in such adaptations; • The alteration/modification is in compliance with applicable laws or requirements for the approval by the appropriate government authorities; and • The alteration/modification expenses do not exceed the usual level of charges for similar alterations/modifications in the locality where the expense is incurred.	

Rehabilitation Benefit		This benefit provides an indemnity payment to the insured to encourage participation in a rehabilitation program designed to help the insured return to work. Participation by the insured in the rehabilitation program must be voluntary and must not be mandatory. To the extent the rehabilitation benefit is not specifically described in the policy form, the insured and insurer must agree in writing to the nature of the benefits and the amount payable.	
Value-added services/non-insurance services	§ 1113(a)(29) § 4224(c) 11 NYCRR 52.1(c) 11 NYCRR 52.17(a)(25) Circular Letter No. 9 (2009) Circular Letter No. 18 (2017)	Value-added services, or non-insurance services, are additional benefits and services offered in connection with the sale of insurance that add value beyond the standard approvable benefits typically associated with disability income insurance. Any value-added service submitted for approval is subject to the following minimum requirements: • Any goods or services offered in the policy or contract shall have a rational nexus to the insurance coverage provided under the policy or contract and shall be necessarily or properly incidental to the insurer's insurance business. Circular Letter No. 9 (2009), Circular Letter No. 18 (2017) • A value-added service shall not run afoul of any rebating and inducement prohibitions and shall be specified in the policy or contract unless the fair market value of the service is $25 or less. The $25 limitation applies to all such valuable consideration in total provided during any policy term. § 4224(c), Circular Letter No. 9 (2009) • The value-added service shall not violate any Insurance law or regulation. • The value-added service should provide the insured with real economic value pursuant to 11 NYCRR 52.1(c). • The value-added service may not terminate at will. Unilateral modifications by an insurer to an existing policy shall be made with at least 30 days' prior written notice to the policyholder. § 52.17(a)(25) • If the value-added service is administered by a third-party administrator, or any other outside vendor, the policy form may not contain language that purports to absolve the insurer of liability to the insured for the vendor's services. *Note: Examples of value-added services that have not been found approvable are legal and financial assistance services, which lack a substantial nexus to disability income insurance. Legal services is also a type of insurance offered pursuant to Insurance Law § 1113(a)(29). See Circular Letter No. 9 (2009)*	
Waiver of Premium Benefit		This benefit waives future premiums due under the policy once the insured experiences a covered disability.	
MANDATORY STATUTORY PROVISIONS		*Note: These provisions MUST be included in each policy and must be no less favorable to the insured than the statutory provision.*	
Arbitration	§ 3216(d)(1)(K)	The policy form cannot provide for mandatory arbitration. An arbitration provision which makes arbitration mandatory conflicts with Insurance Law § 3216(d)(1)(K) since it precludes an insured from bringing an action at law or equity.	
Change of Beneficiary	§ 3216(d)(1)(L)	When applicable, unless the insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to the insured. The consent of the beneficiary or beneficiaries shall not be a requisite to surrender or assignment of this right to change the beneficiaries of the policy or other changes in the policy.	

		Note: The insurer may omit the portion relating to an irrevocable designation of a beneficiary if it is not applicable.	
Claim Forms	§ 3216(d)(1)(F)	The insurer, upon receipt of notice of claim, must provide the claimant with the forms usually furnished for filing proofs of loss. If the forms are not furnished within 15 days after the claimant gives notice of claim, the claimant shall be deemed to have complied with the requirements of the policy for submitting proof of loss upon submitting within the time frame set in the policy for filing proofs of loss, written proof of the occurrence, and the character and extent of the loss for which claim is made.	
Entire Contract	§ 3204 § 3216(d)(1)(A)	The policy form, including any endorsements or attached papers (if any), constitutes the entire contract of insurance. No change in the policy will be valid unless it is approved by an executive officer of the insurer and the approval is endorsed on or attached to the policy. No agent or broker has the authority to change the policy or waive any of its provisions. Incorporation by reference is not permitted.	
Grace Period	§ 3216(d)(1)(C)	The policy should include a grace period for the payment of premiums falling due after first premium of seven days for weekly premium policies, 10 days for monthly premium policies and 31 days for all other policies. During grace period the policy continues in force. *Note: If the insurer reserves the right to refuse to renew the insurer must add to the beginning of the following grace period language: "Unless not less than 30 days prior to the renewal date the insurer has delivered to the insured or has sent by first class mail to his or her last address as shown by the records of the insurer written notice of its intention to not renew this policy beyond the period for which premium has been accepted."*	
Legal Action	§ 3216(d)(1)(K)	No action in law or equity shall be brought to recover on the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.	
Military Suspension	§ 3216(c)(13) § 3216(c)(14) 11 NYCRR 52.17(a)(9) Circular Letter No. 7 (2003)	Any insured who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon written request, to have their coverage suspended during a period of active duty of up to five years. The policy form shall provide that the insurer will refund any unearned premiums for the period of such suspension. Persons covered by the policy shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty, with no limitations or conditions imposed as a result of such period of active duty except as set forth in below. Coverage shall be retroactive to the date of termination of the period of active duty. Such right of resumption provided for herein shall be in addition to other existing rights granted pursuant to state and federal laws and regulations and shall not be deemed to qualify or limit such rights in any way. No exclusion or waiting period may be imposed in connection with coverage of a health or physical condition of a person entitled to such right of resumption, or a health or physical condition of any other person who is covered by the policy unless: the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty; or a waiting period was imposed and had not been completed prior to the period of suspension; in no event, however, shall the sum of the waiting periods imposed prior to and subsequent to the period of suspension exceed the length of the waiting period originally imposed.	

Notice of Claim	§ 3216(d)(1)(E)	Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer (insert the location of such office as designated for this purpose), or to any authorized agent or broker of the insurer, with such information necessary to identify the insured, shall be deemed notice to the insurer.	
Payment of Claims (Indemnity for Loss of Life)	§ 3216(d)(1)(I)	Any indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed in the policy and effective at time of payment. If no designation or provision is effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid to either such beneficiary or estate. All other indemnities will be payable to the insured. *Note: The following provisions, one or both, may be included with the above provision at the option of the insurer: "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $ (insert an amount which shall not exceed one thousand dollars), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment. Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person."*	
Physical Examinations and Autopsy	§ 3216(d)(1)(J)	The insurer at its own expense shall have the right and the opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in the case of death where it is not forbidden by law.	
Premium Payment Period	§ 3216(f)	Coverage is provided to the end of the premium payment period when premium is taken. *Note: For example, if the insurer has accepted premium for a time period during which retirement or employment cessation occurs, coverage must be provided to the end of the time period for which premium has been accepted.*	
Proof of Loss	§ 3216(d)(1)(G)	Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 120 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.	
Reinstatement	§ 3216(d)(1)(D)	If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of the premium by the insurer or by any agent or broker duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. However, that if the insurer or such agent or broker requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be	

		reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement. *Note: The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums 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.*	
Return of Premium Upon Death	§ 3228	The policy form provides that if the death of the insured or covered dependent occurs during a period for which the premium for the policy has been paid, the insurer shall refund the premium or the portion of the premium actually paid by the insured for that person for any period beyond the end of the policy monthly in which the death occurred..	
Time Limit on Certain Defenses	§ 3216(d)(1)(B)	After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period. *Note: The above policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of subparagraphs (A) through (E), inclusive, of this paragraph in the event of misstatement with respect to age or occupation or other insurance.* *Note: 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 5 years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE": "After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application."* No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.	
Time of Payment of Claims	§ 3216(d)(1)(H)	Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic	

		payment will be paid (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.	
OPTIONAL STANDARD PROVISIONS		*These provisions MAY be included at the insurer's option. If they are included the provision must be no less favorable to the insured than the statutory provision.*	
Benefit Offsets	§ 3216(d)(2)(C)-(F) 11 NYCRR 52.23(e)(3)(i)	If the insurer wishes to offset the benefits, select from the following provisions: § 3216(d)(2)(C) OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and health policy or policies previously issued by the insurer to the insured are in force concurrently herewith, making the aggregate indemnity for (insert type of coverage(s)) in excess of $ (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to the estate, or, in lieu thereof. Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, the beneficiary or the estate, as the case may be, and the insurer will return all premiums paid for all other such policies. § 3216(d)(2)(D) INSURANCE WITH OTHER INSURERS: If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage. § 3216(d)(2)(E) INSURANCE WITH OTHER INSURERS: If there is other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined. *Note: If Insurance Law § 3216(d)(2)(D) and (E) are included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "EXPENSE INCURRED BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the superintendent, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the superintendent. In the absence of*	

		such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third-party liability coverage shall be included as "other valid coverage". § 3216(d)(2)(F) RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or the greater of average monthly earnings for the period of 2 years immediately preceding a disability for which claim is made the insurer will be liable for only such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such 2 years as shall exceed the pro-rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time. *Note: The above provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty or, in the case of a policy issued after age 44, for at least 5 years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the superintendent, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by the insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the superintendent or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.* *Pursuant to 11 NYCRR 52.18(d) and 52.23(e)(3)(i), coordination of benefits is not allowed in an individual insurance policy. Insurers may financially underwrite for other coverage before issuance and may use the above provisions for excess insurance situations after issuance.*	
Cancellation	§ 3216(d)(2)(H)	Within the first 90 days after the date of issue, the insurer may cancel this policy by written notice delivered to the insured or sent by first class mail to the last address as shown by the records of the insurer, stating when, not less than 10 days thereafter, such cancellation shall be effective. In the event of cancellation, the insurer will return promptly the pro-rata unearned portion of any premium	

		paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. *Note: Nothing in this provision shall be construed to prohibit an insurer from granting to the insured the right to cancel a policy at any time and to receive in such event a refund of the unearned portion of any premium paid, computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued.*	
Change in Occupation	§ 3216(d)(2)(A)	If the insured is injured after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro-rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.	
Conformity with State Statutes	§ 3216(d)(2)(I)	Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.	
Elimination Periods	§ 3201(c)(3)	Elimination periods of no longer than 180 days are viewed as reasonable. Elimination periods of any longer duration may work a hardship on a disabled insured. Insurers seeking approval of elimination periods that exceed 180 days should explain why the elimination period is necessary and how they will mitigate the hardship on the disabled insured.	
Misstatement of Age	§ 3216(d)(2)(B)	If the insured's age has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.	
Pre-Existing Conditions	§ 3201(c)(3) § 3216(d)(1)(B)(ii) 11 NYCRR 52.2(v) 11 NYCRR 52.16(c)(1) 11 NYCRR 52.17(a)(27) 11 NYCRR 52.17(a)(28)	The policy form may include a pre-existing condition exclusion provision that defines a pre-existing 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 the coverage of the insured person, 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 for the insured person. Age 65 or older: If the policy form is issued persons age 65 or older, it may exclude, limit or reduce coverage for a loss due to pre-existing condition for a period no greater than six months following the effective	

		date of coverage, unless the pre-existing condition is specifically excluded at coverage issuance through means of a waiver or exclusionary rider. Under age 65 and not underwritten: If the policy form is NOT underwritten and is issued to persons under age 65, it may exclude, limit or reduce coverage for a loss due to pre-existing condition for a period no greater than 12 months following the effective date of coverage, unless the pre-existing condition is specifically excluded at coverage issuance through means of a waiver or exclusionary rider. Under age 65 and underwritten: If the policy form is underwritten and is issued to persons under age 65, it may exclude, limit or reduce coverage for a loss due to pre-existing condition for a period no greater than 24 months following the effective date of coverage, unless the pre-existing condition is specifically excluded at coverage issuance through means of a waiver or exclusionary rider.	
Subrogation	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a)	Any subrogation provision must comply with the General Obligations Law that affects an insurer's reimbursement rights. When an insured settles a claim, whether in litigation or otherwise, against one or more other persons for personal injuries, medical, dental, or podiatric malpractice, or wrongful death, it shall be conclusively presumed that the settlement does not include any compensation for the cost of health care services, loss of earnings or other economic loss to the extent those losses or expenses have been or are obligated to be paid or reimbursed by an insurer. By entering into any such settlement, an insured shall not be deemed to have taken an action in derogation of any right of any insurer that paid or is obligated to pay those losses or expenses; nor shall an insured's entry into such settlement constitute a violation of any contract between the insured and such insurer. No insured entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by an insurer and an insurer shall have no lien or right of subrogation or reimbursement against any such settling person or any other party to such a settlement, with respect to those losses or expenses that have been or are obligated to be paid or reimbursed by said insurer.	
Unpaid Premium	§ 3216(d)(2)(G)	Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.	
Unilateral Modification	11 NYCRR 52.17(a)(25)	Unilateral modifications by an insurer to an existing policy must be made with at least 30 days' prior written notice to the policyholder. When a policyholder is contractually required to provide prior written notice to terminate coverage, an insurer must provide notice of a unilateral modification at least 14 days prior to the date by which the policyholder is required to provide notice to terminate coverage.	
PERMISSIBLE EXCLUSIONS & LIMITATIONS		*Only the following exclusions or limitations are permissible. Not all exclusions must be included, but if an exclusion or limitation is included the language from the statute or regulation must be used.*	
Alcoholism and Drug Addiction	11 NYCRR 52.16(c)(2)	This policy form may exclude coverage for alcoholism or drug addiction.	
Aviation	11 NYCRR 52.16(c)(4)(iii)	This policy form may exclude for coverage for illness, accident, treatment, or medical condition arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	

Chiropractic Care	11 NYCRR 52.16(c)(7)	This policy may exclude coverage for care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.	
Convalescent, Custodial Care and Transportation	11 NYCRR 52.16(c)(11) 11 NYCRR 52.25(a)(1)	This policy form may exclude coverage for rest cures, custodial care, and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities.	
Cosmetic Surgery	11 NYCRR 52.16(c)(5)	This policy may exclude coverage for cosmetic surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. *Note: All exclusions for cosmetic surgery must be based on medical necessity, with the insured receiving all utilization review and external appeal rights under Article 49.*	
Coverage Outside of the United States, Canada or Mexico	11 NYCRR 52.16(c)(12)	The policy form may exclude for coverage while the insured is outside of the United States, its possessions, Canada or Mexico.	
Dental Care	11 NYCRR 52.16(c)(9)	The policy form may exclude coverage of dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and for dental care or treatment necessary due to congenital disease or anomaly.	
Extra-hazardous Activities	11 NYCRR 52.16(e) 11 NYCRR 52.2(i)	The policy form may exclude coverage for extra-hazardous activities in accordance with 11 NYCRR 52.16(e). The insurer must seek a signed waiver of coverage signed by a prospective insured or, in the alternative, place the extra-hazardous activity exclusionary language on the cover page or specification page of the policy. For additional information, see the "Extra-hazardous Activities" section under "Application Forms." *Note: The Department has determined that the following activities are not "extra-hazardous" as defined by 11 NYCRR 52.2(i) and may not be excluded under a policy form: base jumping, bungee jumping, caving, parasailing, parkour, mountain or rock climbing, or scuba diving. This list is not meant to be exhaustive.*	
Eyeglasses, Hearing Aids and Exams	11 NYCRR 52.16(c)(10)	The policy form may exclude coverage for eyeglasses, hearing aids, and examination for the prescription or fitting thereof.	
Felony Participation, Riot or Insurrection	§ 3216(d)(2)(J) 11 NYCRR 52.16(c)(4)(i)	The policy form may exclude coverage for any illness, accident, treatment or medical condition due to the insured's participation in a felony, riot or insurrection.	
Foot Care	11 NYCRR 52.16(c)(6)	The policy form may exclude coverage for foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.	
Government Hospital	11 NYCRR 52.16(c)(8)	The policy form may exclude coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise provided by law.	
Illegal Occupation	§ 3216(d)(2)(J)	The policy form may exclude losses to which a contributing cause was the insured's commission of or an attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.	
Immediate Family	11 NYCRR 52.16(c)(8)	The policy form may exclude services performed by a member of the insured's immediate family. Immediate family has the same meaning as defined in 42 CFR § 411.351: husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law,	

		mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.	
Intoxicants and Narcotics	§ 3216(d)(2)(K)	The policy form excludes coverage for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.	
Medicare, Other Government Programs and Workers' Compensation	11 NYCRR 52.16(c)(8) OGC Opinion 06-12-09	The policy form may exclude coverage for benefits provided under Medicare or other government programs (except Medicaid) or any state or federal workers' compensation, employers' liability or occupational disease law, unless where otherwise provided in State or Federal statute.	
Mental Health or Substance Use Disorders	11 NYCRR 52.16(c)(2)	The policy form may exclude coverage of mental health or substance use disorders. If the policy provides coverage for mental health or substance use disorders, coverage should be provided for at least 24 months and should be provided for any mental health or substance use disorder.	
Military Service	11 NYCRR 52.16(c)(4)(i)	The policy form may exclude coverage for a disability due to service in the armed forces or auxiliary units.	
No-Fault Automobile Insurance	11 NYCRR 52.16(c)(8)	The policy form may exclude coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.	
Pregnancy	11 NYCRR 52.16(c)(3) 11 NYCRR 52.2(e)	The policy form may exclude coverage for pregnancy except for complications of pregnancy. See the "Complications of Pregnancy" definition under the "Definitions" section.	
Services Separately Billed by Hospital Employees	11 NYCRR 52.16(c)(8)	The policy form may exclude coverage for services rendered and separately billed by employees of hospitals, laboratories, or other institutions.	
Services For Which No Charge Is Normally Made	11 NYCRR 52.16(c)(8)	The policy form may exclude coverage for services for which no charge is normally made.	
Suicide, Attempted Suicide, Intentionally Self-Inflicted Injury	11 NYCRR 52.16(c)(4)(ii)	The policy form may exclude coverage for illness, accident, treatment, or medical condition arising out of suicide, attempted suicide, or intentionally self-inflicted injury. *Note: No distinction is made for whether the insured is sane or insane*.	
War or Act of War	11 NYCRR 52.16(c)(4)(i)	The policy form may exclude coverage for illness, accident, treatment or medical condition arising out of war or act of war (whether declared or undeclared). *Note: Exclusions for terrorism are not permitted.*	
RATE RELATED INFORMATION			
Attained Age Rates	11 NYCRR 52.17(a)(29)	If the rates are based upon attained age, the policy forms contain the applicable schedule of rates.	
Level Premium	11 NYCRR 52.40(b)(1)(ii)	If the rates in the filing are level premium, the policy is "Guaranteed Renewable," "Non-Cancellable," or provides that non-renewal is subject to the approval of the Superintendent.	
Sex Basis for Rates	11 NYCRR 52.41	The policy form is rated on the following basis (select only one): ☐ Unisex basis; OR ☐ Sex-distinct basis and will NOT be issued in any employer/employee situation subject to the Norris decision and/or Title VII of the Civil Rights Act of 1964.	
SCHEDULE OF BENEFITS			
Benefit Selections	§ 3204(a)(1) 11 NYCRR 52.31(f)	The schedule page sets forth: • The principal sum amounts, daily benefit amounts, monthly benefit amounts and similar choices made by the insured.	

		• Optional choices made by the insured regarding certain benefits and/or riders selected by the insured.	
Effective Date and Renewal Dates	§ 3216(c)(2) 11 NYCRR 52.31(f)	The schedule page includes spaces for effective date of insurance, renewal dates and renewal terms.	
Hypothetical Data	11 NYCRR 52.31(f)	The schedule page is completed with hypothetical data.	
Name of Insured	§ 3216(c)(3) 11 NYCRR 52.31(f)	The schedule page includes space for the insured's name and covered family members.	
Premium Summary	§ 3216(c)(1) 11 NYCRR 52.31(f)	The schedule page contains premium summary amounts and provisions dealing with insured participation status in surplus or dividends. *Note: The insurer may only offer discounts that are determined by the Health Bureau's Rating Section to be justifiable discounts before being placed on file by the Rating Section.*	
ACTUARIAL SECTION FOR NEW PRODUCT RATE REQUIREMENTS		Complete this section for all forms filings except those filings where a rate filing is unnecessary because: (select one) ☐ The submission contains only application forms, disclosure statements, and/or advertising; OR ☐ The submission is an out-of-state filing pursuant to Insurance Law § 3201(b)(2); OR ☐ The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate. (For rate changes to existing products, do NOT complete this section – complete the Existing Products Rate Requirements section below instead.)	Form & Page Number
ACTUARIAL MEMORANDUM	11 NYCRR 52.40(a)(1)	The actuary preparing the filing meets the following actuarial qualifications: a. Member of the Society of Actuaries; and b. The "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	11 NYCRR 52.40(d)(1) 11 NYCRR 52.45	The rates must be actuarially justified, and the justification of rates should include: a. Outline of the benefits and coverages, and specific formulas and supporting assumptions used in calculating rates; b. Expected claim costs in the aggregate; c. Actuarial justification and derivation (including all assumptions) for each benefit provided; d. Description of gross premium differentials based on sex; e. Description of marketing methods; f. If there are risk classifications, please describe them and provide the actuarial justification thereof; g. Non-claim expense components as a percentage of gross premium; and h. Demonstration of expected loss ratio.	
Loss Ratios	11 NYCRR 52.45	The expected loss ratio must be submitted with actuarial justification.	
Reserve Bases	11 NYCRR 94	Description of bases for all reserves (if applicable).	
Underwriting	11 NYCRR 52.40(c)(2)(vi) and (vii)	Description of underwriting rules that are related to rate determination.	
Actuarial Certification	11 NYCRR 52.40(a)(1)	The filing must provide an actuarial certification that states that: a. The filing is in compliance with all applicable laws and regulations of the State of New York; b. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans" as adopted by the Actuarial Standards Board; c. The expected loss ratio meets the minimum requirements of the State of New York;	

		d. The benefits are reasonable in relation to the premiums charged; and e. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification		The expected loss ratios are _____ %.	
ACTIVE RATE MANUAL	11 NYCRR 52.40(c)(2)	The rate manual must include: a. Table of Contents; b. Rate pages; c. Insurer name on each consecutively numbered rate page; d. Identification by form number of each policy, rider, or endorsement to which the rates apply; e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits; f. Description of rating classes; g. Examples of rate calculations; h. Commission schedule(s); i. Underwriting guidelines and/or underwriting manual; and j. Expected loss ratios.	
ACTUARIAL SECTION EXISTING PRODUCTS RATE REQUIREMENTS		(For new products, do NOT complete this section – complete the New Products-Rate Requirements section above.) Complete this section for all filings of changes in rates (e.g., rate increases/decreases or changes in rate calculation rules or procedures), commissions or underwriting to existing products.	
ACTUARIAL MEMORANDUM	11 NYCRR 52.40(a)(1)	The actuary preparing the filing meets the following actuarial qualifications: a. Member of the Society of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates		The rates must be actuarially justified, and the justification of rates should include: a. Description of benefits and changes in benefits (if any); b. History of previous New York rate revisions. If nationwide experience is included, a history of previous non-New York rate revisions should be included; c. Complete New York experience since inception, including: • Yearly and in total; • All items except reserves accumulated with interest (accumulated from midpoint of calendar year to most recent as of Dec. 31); • Yearly and in total, but with premiums adjusted to the current New York rate schedule. Describe the basis for all reserves. d. First and last years of issue; e. Actual and expected loss rations for each type of provided benefit; f. Derivation of proposed rate revision in detail, including demonstration that: • The expected future loss ratio and expected lifetime loss ratio are at least as large as the disclosure loss ratio; and • The expected future loss ratio is at least as large as the applicable minimum loss ratio g. Statement that the rates when approved will be applied to all policies originally delivered or issued for delivery in New York State, regardless of place of current residence.	
Actuarial Certification	11 NYCRR 52.40(a)	An Actuarial Certification should be included that states that: a. The filing is in compliance with all applicable laws and regulations of the State of New York;	

		b. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans"; c. The expected loss ratio meets the minimum requirements of the State of New York; d. The benefits are reasonable in relation to the premiums charged; and e. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification		The expected loss ratio is: %.	
REVISED RATE MANUAL PAGES	11 NYCRR 52.40(c)(2)	A revised Rate Manual should include: a. Table of Contents; b. Rate pages; c. Insurer name on each consecutively numbered rate page; d. Identification by form number of each policy, rider, or endorsement to which the rates apply; e. Brief description of benefits, types of coverage, limitations, exclusions; f. Description of rating classes; g. Examples of rate calculations; h. Commission schedule(s); i. Underwriting guidelines and/or underwriting manual; and j. Expected loss ratio	