

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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I, Benjamin M. Lawskey, Superintendent of Financial Services, pursuant to the authority granted by Sections 202 and 302 of the Financial Services Law and Section 301 of the Insurance Law, do hereby promulgate the following amendments to Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York, to take effect August 1, 2013, and to read as follows:

(MATTER IN BRACKETS IS DELETED; NEW MATTER IS UNDERLINED)

Section 1.1 is amended as follows:

A regulation is an official act of the superintendent of general application, that is, a statement of a rule applicable to future as well as existing situations, and applicable to all or any class of insurers, agents, brokers, adjusters, employees of the [Insurance] Department of Financial Services, or other persons subject to being regulated by the Superintendent of [Insurance] Financial Services.

Section 1.3 is amended as follows:

An opinion is an informal statement of the interpretation or construction of any law or official regulation of the superintendent, in reference to a particular situation involving the exercise of any authority of the superintendent under the Insurance Law, when made by an official or salaried employee of the [Insurance] Department of Financial Services in the regular course of his or her duties.

Section 2.3 is amended as follows:

All regulations shall be signed by the superintendent in duplicate and the duplicate originals shall be kept in two sets of loose-leaf books, of which one shall be kept in the offices of the [Insurance] Department of Financial Services in Albany and in the City of New York. These copies are not to be taken from the [Insurance] Department of Financial Services except under order of court. It shall be the duty of the department counsel, or of a deputy superintendent designated for that purpose, to see that all regulations are consecutively numbered, properly recorded and indexed by reference to subject matter and to the section or sections of the Insurance Law. The regulations and index shall be open to public inspection.

Section 2.5(b) is amended as follows:

(b) In case the proposed opinions will conflict with any other known opinion or with any regulation or practice of the [Insurance] Department of Financial Services, the department counsel or a deputy superintendent should be consulted.

Section 2.5(f) is amended as follows:

(f) If an opinion is deemed to be sufficiently important as a guide to the future action of the [Insurance] Department of Financial Services to justify keeping a permanent record thereof, the opinion shall be filed and retained in accordance with internal department procedures. The public disclosure of opinions shall be subject to the provisions of the Freedom of Information Law and Part 241 of this Title (Insurance Regulation 71).

Section 3.2 is amended as follows:

Within 30 days after the filing with the Superintendent of [Insurance] Financial Services of the administration ticket for any such election of directors, pursuant to subsection (g) of section 4210, every such company shall cause to be published the names of the candidates on such ticket, a brief identification of each and a statement that such persons have been nominated by the board of directors of such company as candidates to fill vacancies in such board at the annual meeting of the company to be held at a time and place therein indicated. Such publication shall be made, at the expense of the company, in two daily newspapers published in this State, which have been approved by the superintendent[,] for such purpose, and in one additional newspaper[,] approved by the superintendent, which is published in one of the larger cities of other states, the residents of which hold a substantial amount of the company's outstanding policies and contracts.

Section 3.4(a) is amended to read as follows:

(a) Notice of the time and place of holding said election shall be given by publication thereof in two newspapers of general circulation, approved by the Superintendent of [Insurance] Financial Services, printed in the city in which the home office is located, twice a week for two successive weeks immediately preceding said election. Proof of publication of the notice of election shall be filed with the inspectors of election prior to the opening of the polls.

Section 3.4(g) and (h) are amended to read as follows:

(g) The votes of said election shall be by ballot, which shall be voted in the form prescribed by the [Superintendent of Insurance] superintendent.

(h) An itemized statement of the expenditures during the conduct of such election and the canvass of the votes shall be reported to the [Superintendent of Insurance] superintendent.

The title of Part 4 is amended as follows:

Part 4. Rules Governing the Procedures for Adjudicatory Proceedings Before the [Insurance] Department of Financial Services.

Section 4.1(a) is amended as follows:

(a) This Part applies to [Insurance] Department of Financial Services [(the department)] (the “department”) adjudicatory proceedings, as defined in section 102(3) of the State Administrative Procedure Act and hearings

held in connection therewith, except it shall not apply to proceedings pursuant to section 4308 of the Insurance Law, which proceedings shall be governed by the provisions of such section.

Section 4.2(a) is amended as follows:

(a) A hearing in an adjudicatory [proceedings] proceeding shall be conducted by a hearing officer chosen from among the following persons:

(1) the Superintendent of [Insurance] Financial Services;

(2) any Deputy Superintendent of [Insurance] Financial Services; or

(3) any competent salaried employee of the department authorized by the superintendent for such purpose.

Section 4.3(a) is amended to read as follows:

(a) An adjudicatory proceeding shall be commenced by service of a notice of action or proposed action as provided in section [303 of the Insurance Law] 304 of the Financial Services Law. Such notice shall be served on each party at least 10 days prior to the return date, except that where another time limitation is specified by statute or regulation, the time limitation for notice contained therein shall govern.

Section 4.4(b) is amended to read as follows:

(b) An attorney representing a party shall file a notice of appearance on a form prescribed by the Superintendent of [Insurance] Financial Services pursuant to sections 166 and 168 of the Executive Law.

Section 4.8(c) is amended to read as follows:

(c) The right of a party to seek judicial review pursuant to section [326 of the Insurance Law] 308 of the Financial Services Law and article 78 of the Civil Practice Law and Rules shall not be restricted, delayed or extended by the provisions of this section.

Section 4.9 is amended to read as follows:

Hearings shall be open to the public as provided in section [304(c) of the Insurance Law] 305(c) of the Financial Services Law. The hearing officer may exclude from the hearing room any person engaging in improper conduct at the hearing, but may not exclude a party or an attorney representing a party.

Section 15.2(a) is amended to read as follows:

(a) Approved policy means an insurance policy approved by the Superintendent of [Insurance] Financial Services as meeting the requirements of Insurance Law section 3101 and of this Part.

Section 16.9(a)(2) is amended as follows:

(2) in which the insurer shall maintain the underwriting files, experience statistics, financial and other records, applicable to business underwritten and transacted under section 6302 of the Insurance Law, subject to examination by the [Insurance] Department of Financial Services as often as the superintendent deems necessary.

Section 17.0(b) and (c) are amended to read as follows:

(b) The Superintendent of [Insurance] Financial Services is to establish standard claim forms after investigation and review of claim forms currently being utilized by commercial insurance companies and health care providers. To assist and advise the superintendent in his investigation and review of claim forms in use, and to provide expert opinion on the content of standard claim forms, the superintendent appointed an Advisory Committee on Standard Claim Forms for Accident and Health Insurance, consisting of representatives from the Hospital Association of New York State, New York State Medical Society, New York State Dental Society, the Office of Health Systems Management, Consumer Protection Board, Health Insurance Association of America and the insurance industry. During the course of the superintendent's investigation, it was revealed with regard to hospital claims, that the great volume of claims processed by hospitals relate to persons covered by Medicaid, Medicare and Blue Cross, with a relatively small percentage of hospital bills paid by commercial insurance companies. Commercial insurance companies are the only payors affected by chapter 545 of the Laws of 1977 and this Part.

(c) In an effort to develop a model data system in New York State for the purposes of health care planning and financing, the Health Care Financing Administration of the United States Department of Health, Education and Welfare awarded a grant in 1977 to the New York State Office of Health Systems Management to establish, among other things, a uniform inpatient hospital billing form. The Superintendent of [Insurance] Financial Services was represented on the Uniform Billing Advisory Committee, which assisted the Office of Health Systems Management Project Staff in the development of a uniform inpatient hospital billing form, which is a single claim form for use by Medicaid, Medicare, Blue Cross and commercial insurance companies).

Section 17.0(i) is amended to read as follows

(i) Under the leadership of the Health Care Financing Administration of the United States Department of Health and Human Services, representatives of the New York State Department of Social Services, the New York State Department of [Insurance] Financial Services, other Federal government agencies, commercial insurers and article IX-C corporations, and other interested parties participated in the establishment of a New York State version of a federally developed physician claim form designed to serve as a single claim form for use by Medicare, Medicaid, commercial insurance companies and article IX-C corporations.

Section 17.1(a) is amended as follows:

(a) The Superintendent of [Insurance] Financial Services hereby [established] establishes standard claim forms for the services performed by physicians and dentists in New York State. For the services provided by hospitals in New York State, the Superintendent of [Insurance] Financial Services establishes as a standard claim form the uniform inpatient hospital billing form prescribed by the Commissioner of Health in section

405.28 (NYCRR 10 Part 405) to be used statewide by all hospitals.

Section 17.2 is amended as follows:

[All] Every commercial [insurers] insurer providing accident and health insurance in New York State and [all] every article IX-C [corporations] corporation shall accept the standard claim forms established by the Superintendent of [Insurance] Financial Services when submitted by physicians, dentists or by a hospital for services rendered in New York State to an individual covered by an accident and health policy, or when submitted directly by an insured for covered services.

Section 20.1 is amended as follows:

Forms of applications for temporary licenses to be issued pursuant to section 2109 of the Insurance Law are prescribed for a temporary broker's license and for a temporary insurance agent's license. These forms may be obtained upon request to the [Insurance] Department of Financial Services, Albany, NY.

Section 20.2 is amended as follows:

Forms of notice of termination of appointment of insurance agents pursuant to section 2112 of the Insurance Law are prescribed as follows: for agents licensed pursuant to section 2103(a) of the Insurance Law; for agents licensed pursuant to section 2103(b) of the Insurance Law. These forms may be obtained upon request to the [Insurance] Department of Financial Services, Albany, NY.

Section 21.1(a) is amended as follows:

(a) The forms of applications for original licenses to act as an insurance broker for life insurance pursuant to section 2104(b)(1)(A) of the Insurance Law, as an insurance broker for all other kinds of insurance pursuant to section 2104(b)(1)(B) of the Insurance Law, and as an excess line broker pursuant to section 2105 of the Insurance Law and as an excess line broker pursuant to section 2105 of the Insurance Law are hereby prescribed as follows: individuals; partnerships; corporations; limited liability companies. These forms may be obtained upon request to the [Insurance] Department of Financial Services, Albany, N.Y. The term "original application" as used in this Part means an application for an insurance broker's or excess line broker's initial license.

Section 21.4 is amended as follows:

Each licensee is required to notify the [Insurance] Department of Financial Services, Albany, New York of any change of business or residence address within thirty days of the change.

Section 22.1 is amended as follows:

The forms of applications for licenses to act as insurance agents pursuant to section 2103 of the Insurance Law are prescribed as follows: individuals; partnerships; corporations; limited liability companies. These forms may be obtained upon request by insurance companies or fraternal benefit societies to the [Insurance] Department of Financial Services, Albany, N.Y.

Section 22.3 is amended as follows:

Each licensee is required to notify the [Insurance] Department of Financial Services, Albany, New York of any change of business or residence address within thirty days of the change.

Section 23.1 is amended as follows:

The forms of applications for licenses to act as insurance agents pursuant to section 2115 of the Insurance Law are hereby prescribed as follows: individuals; partnerships or associations; corporations; limited liability companies. These forms may be obtained upon request by insurers to the [Insurance] Department of Financial Services, Albany, NY.

Section 23.4 is amended as follows:

Each licensee is required to notify the [Insurance] Department of Financial Services, Albany, NY of any change of business or residence address within 30 days of the change.

Section 24.1 is amended as follows:

The forms of applications for certification of officers and employees of insurers pursuant to section 2202 of the Insurance Law may be obtained upon request by an insurer to the [Insurance] Department of Financial Services, Albany, NY.

Section 24.3 is amended as follows:

Forms of notice of termination of any officer or employee pursuant to the provisions of section 2206 of the Insurance Law may be obtained upon request to the [Insurance] Department of Financial Services, Albany, NY.

Section 25.1 is amended as follows:

The forms of applications for original licenses to act as a public adjuster pursuant to section 2108 of the Insurance Law are hereby prescribed as follows: individuals; partnerships; corporations; limited liability companies. These forms may be obtained upon request to the [Insurance] Department of Financial Services, Albany, NY. The term “original application”, as used in this Part, means an application for a public adjuster’s initial license.

Section 25.3(b) and (c) are amended as follows:

(b) No such licensee or sublicensee shall divide any fee or give any fee, commission or other compensation to any person, firm or corporation for procuring, or assisting in procuring, the adjustment of any such loss for any such licensee or sublicensee, unless the person, firm or corporation to whom such fee, commission or other compensation is given or paid had at the time when the loss occurred:

- (1) a public adjuster's license issued and in force pursuant to section [123] 2108 of the Insurance Law; or

(2) an insurance broker's license issued and in force and such licensee either was the broker of record in placing the insurance which was involved in the adjustment of the loss, whether or not designated in writing to act for the insured, or was designated to act for the insured in writing before a loss occurred.

(c) No such licensee or sublicensee shall be employed, or associated with, any person, partnership, corporation, member, officer, director or stockholder, whose license as a public adjuster has been revoked by the Superintendent of [Insurance] Financial Services of New York. Any violation of this Part shall be deemed a ground for refusal to issue or renew, or for revocation or suspension of, a public adjuster's license.

Section 25.4 is amended as follows:

Each licensee [is required to] shall notify the [Insurance] Department of Financial Services, Albany, NY of any change of business or residence address within 30 days of the change.

Section 26.1 is amended as follows:

The forms of application for original licenses to act as an independent adjuster pursuant to section 2108 of the Insurance Law are hereby prescribed as follows: individuals; partnerships; corporations; limited liability companies. These forms may be obtained upon request to the [Insurance] Department of Financial Services, Albany, NY. The term "original application" as used in this Part, means an application for an independent adjuster's initial license.

Section 26.5 is amended as follows:

No independent adjuster licensee or sublicensee shall divide any fee or give any fee, commission or other compensation to any person, firm or corporation for procuring or assisting in procuring the adjustment of any loss for such licensee or sublicensee, unless the person, firm or corporation to whom such fee, commission or other compensation is given or paid had at the time when the loss occurred, an independent adjuster's license issued and in force pursuant to section 2108 of the Insurance Law. No such licensee or sublicensee shall be employed or associated with any person, partnership, corporation, member, officer, director or stockholder, whose license as an independent adjuster has been revoked by the Superintendent of [Insurance] Financial Services of New York. Any violation of this Part shall be deemed a ground for refusal to issue or renew, or for revocation or suspension of, an independent adjuster's license.

Section 26.6 is amended as follows:

Each licensee [is required to] shall notify the [Insurance] Department of Financial Services, Albany, NY, of any change of business or residence address within 30 days of the change.

Section 27.7(b) is amended as follows:

(b) The reports required by this section shall be submitted, in a format and utilizing such written or electronic media as prescribed by or satisfactory to the superintendent, to:

New York State [Insurance] Department of Financial Services
Property Bureau
Attention: Excess Line Unit
[25 Beaver] One State Street
New York, NY 10004

Section 29.5 is amended as follows:

(a) Any licensee who receives any fees and/or commissions, or shares thereof, in connection with any insurance services rendered to, or insurance coverages placed or serviced on behalf of, a governmental unit, shall file, with the [Insurance] Department of Financial Services and the most senior official of the governmental unit [which] who ordered such insurance services or coverages, a completed “Governmental Insurance Disclosure Statement”, affirmed by the licensee as true under penalties of perjury, on the prescribed form attached hereto as Exhibit B, which statement after filing shall be a public record.

(b) Statements shall be filed with the Licensing [Services] Bureau,] of the [Insurance] Department of Financial Services, at the Albany office of the [Insurance] Department, on or before the 15th day of April in each year with respect to fees and/or commissions, or shares thereof, received as of the preceding December 31st. A general agent, as defined in this Part, shall not be required to file a Governmental Insurance Disclosure Statement with respect to insurance coverages placed in his capacity as a general agent, or on account of which commissions or shares thereof are paid to another agent or broker who ordered such coverages from said general agent.

Section 29.6 is amended as follows:

(a) [The form formally printed as Exhibit A in this section, approved for use as specified in this Part on December 1, 1978, is repealed

(b) The form in [Exhibit B] subdivision (b) of this section is hereby approved for used as specified in this Part. Any licensee may request the return of disclosure statements heretofore or hereafter filed with the [Insurance] Department of Financial Services [on the repealed form], provided such request is made in writing to the Licensing [Services] Bureau at the Albany office of the [Insurance] Department of Financial Services and is accompanied by a self-addressed, postage paid envelope suitable for the return of such disclosure statements.

(b) Governmental Insurance Disclosure Statement

[EXHIBIT B]
Governmental Insurance Disclosure Statement
[For Use On And After December 31, 1979]

Pursuant to 11 NYCRR 29.5 (Insurance Regulation 87), the undersigned hereby affirms, under the penalties of perjury, that the statements made hereinafter are true.

Filed By: Name:

Address:

1. Name of governmental unit [which] that ordered insurance services and/or coverages.
2. Name and office address, including county, of person who placed the order for insurance services or coverages:
3. Will you share any fees or commissions received on account of business listed in item 1 with any other licensee(s) or other person(s), directly or indirectly?

YES NO

4. Are you a public officer or party officer?

YES NO

If you answered NO to items 3 and 4, you are not required to answer items 5 through 10. You must sign and date the form where indicated and mail it to the address indicated below.

If you answered YES to items 3 or 4, you are required to complete the remaining applicable items, and you must sign and date the form where indicated and mail it to the address indicated below.

5. Names and addresses of licensees or others to whom you paid fees and/or commissions:
6. The dollar amount you paid to each licensee or other person.
7. The services rendered by the persons listed in item 5, for which a share of commissions [were] was paid.
8. Schedule of coverages placed on account, of which fees or commissions were paid to the persons listed in item 5:

Name of Insurer

Policy #

9. Services rendered on account, of which fees were paid to the persons listed in item 5.

10. What public office or party office do you hold?

Date: _____

Signature
Type name of person whose signature
appears above:

Telephone No.: _____

Mail the original disclosure statement to:
New York State [Insurance] Department of Financial Services
Licensing [Services] Bureau
Governmental Insurance Disclosure Unit
One Commerce Plaza - 20th Floor
Albany, NY 12257

Mail a copy of the disclosure statement to the most senior official of the governmental unit [which] who ordered the insurance services or coverages listed thereon.

Section 31.1(a) is amended as follows:

(a) When the Superintendent of [Insurance] Financial Services finds that public health, safety or welfare imperatively requires emergency action, and incorporates a finding to that effect in such order, summary suspension of a license may be ordered, effective on the date specified in such order or upon service of a certified copy of such order on the licensee, whichever shall be later, pending proceedings for revocation or other action.

Section 31.1(c) is amended as follows:

(c) The order of summary suspension shall be served upon the holder of a license, either by personal service or in the manner prescribed by section [303 of the Insurance Law] 304 of the Financial Services Law and in accordance with section 401 of the State Administrative Procedure Act.

Section 31.2(f) is amended as follows:

(f) Decisions of the hearing officer shall, pursuant to section [304 of the Insurance Law] 305 of the Financial Services Law, be subject to adoption by the superintendent.

Section 33.0 is amended as follows:

Some insurance companies have entered into contracts with individuals or organizations, commonly referred to as managing general agents or managers, to manage all or part of their insurance business. This may represent a shifting of an insurance company's responsibilities to a person, firm, association or corporation outside of its organization. This Part is promulgated because the [Insurance] Department of Financial Services is concerned that such delegation of authority has been subject to abuses detrimental to both insurance companies and insureds.

Section 33.4(b) is amended as follows:

(b) Nothing contained in this Part shall exempt any person from any requirement to be licensed as an insurance agent, reinsurance intermediary or otherwise under the Insurance Law or from being subject to examination by the [Insurance] Department of Financial Services.

Section 34.0 is amended as follows:

The purpose of this Part is to interpret and implement the provisions of section 2129 of the Insurance Law, which requires all insurance agents and insurance brokers who have established one or more places of business to have at least one properly licensed supervising person at each place of business, including the headquarters location. Section 2129 also requires that written notice be given to the Superintendent of [Insurance] Financial Services of each satellite office and the identity of the supervising person responsible for each satellite office.

Section 34.4(b) is amended as follows:

(a) Every agent or broker that maintains more than one place of business must give written notice to the [Insurance] Department of Financial Services, Licensing Bureau, One Commerce Plaza, Albany, NY 12257. The notice shall specify the location of each satellite office and the supervising person or persons responsible for each satellite office. The notice must include the license numbers of the agent or broker and the supervising person, and shall be signed by the agent and broker, or a sublicensee or a licensed partner, where appropriate, and by the supervising person.

Section 39.1(a) is amended as follows:

(a) Policies/certificates sold in conjunction with the program must be approved by the Superintendent of [Insurance] Financial Services of New York State as meeting the minimum standards required under this Part and other pertinent authority as required by law. Policies/certificates approved as meeting the requirements stated herein shall be designated as qualified by the presence of a program logo that shall be displayed on any products advertised, marketed, offered, or sold. The program logo on each policy/certificate sold shall be numbered. In addition, each approved policy/certificate sold will include a notice to the insured stating that the policy/certificate qualifies under the program.

Section 39.3(b)(9) is amended as follows:

(9) Level premium. Step rate premiums, policy/certificate options to increase benefits, or any premium payment feature where the premium rate rises automatically after issuance shall not be permitted. Premiums for qualifying policies/certificates shall be level for the duration of the policy/certificate except where a rate increase is granted by the Superintendent of [Insurance] Financial Services for all persons covered by a specific policy/certificate form.

Section 39.4(b)(9) is amended as follows:

(9) Level premium. Step rate premiums, policy/certificate options to increase benefits, or any premium payment feature where the premium rate rises automatically after issuance shall not be permitted. Premiums for

qualifying policies/certificates shall be level for the duration of the policy/certificate except where a rate increase is granted by the Superintendent of [Insurance] Financial Services for all persons covered by a specific policy/certificate form.

Section 39.5(b)(12) is amended as follows:

(12) Level premium. Step rate premiums, policy/certificate options to increase benefits, or any premium payment feature where the premium rate rises automatically after issuance shall not be permitted. Premiums for qualifying policies/certificates shall be level for the duration of the policy/certificate except where a rate increase is granted by the Superintendent of [Insurance] Financial Services for all persons covered by a specific policy/certificate form.

Section 39.6(b)(12) is amended as follows:

(12) Level premium. Step rate premiums, policy/certificate options to increase benefits, or any premium payment feature where the premium rate rises automatically after issuance shall not be permitted. Premiums for qualifying policies/certificates shall be level for the duration of the policy/certificate except where a rate increase is granted by the Superintendent of [Insurance] Financial Services for all persons covered by a specific policy/certificate form.

Section 40.2(d) is amended as follows:

(d) Department means the [Insurance] Department of Financial Services of the State of New York and any employee of the department authorized to act on behalf of the department.

Section 40.2(v) is amended as follows:

(v) Superintendent means the Superintendent of [Insurance] Financial Services of the State of New York and any employee of the department authorized to act on behalf of the superintendent.

Footnotes 1, 2 and 3 to Section 41.2 are amended as follows:

[FN1] Internal Revenue Code, 26 U.S.C. section 101, current through P.L. 109-94, published by U.S. Government Printing Office, Pittsburgh, PA, is available for public inspection at the [Insurance] Department of Financial Services offices at One Commerce Plaza, Albany, NY 12257 and at [25 Beaver] One State Street, New York, NY 10004.

[FN2] Internal Revenue Code, 26 U.S.C. section 4980C, current through P.L. 109-94, published by U.S. Government Printing Office, Pittsburgh, PA, is available for public inspection at the [Insurance] Department of Financial Services offices at One Commerce Plaza, Albany, NY 12257 and at [25 Beaver] One State Street, New York, NY 10004.

[FN3] Internal Revenue Code, 26 U.S.C. section 7702B, current through P.L. 109-94, published by U.S. Government Printing Office, Pittsburgh, PA, is available for public inspection at the [Insurance] Department of Financial Services offices at One Commerce Plaza, Albany, NY 12257 and at [25 Beaver] One State Street, New York, NY 10004.

Section 43.2(ad) is amended as follows:

(ad) Superintendent means the Superintendent of [Insurance] Financial Services of this State, and any employee of the [Insurance] Department of Financial Services of this State authorized to act on behalf of the superintendent.

Section 44.3(u) is amended as follows:

(u) Superintendent means the Superintendent of [Insurance] Financial Services of this State.

Section 51.1(a) is amended as follows:

(a) To implement the Insurance Law of New York by regulating the acts and practices of insurers, agents, brokers and other licensees of the [Insurance] Department of Financial Services with respect to the internal and external replacement of life insurance policies and annuity contracts.

Section 51.3(b) is amended as follows:

(b) A policy change customarily granted by the insurer is being exercised, provided such change results in no additional surrender or expense charge or suicide or contestable restrictions, and only to the extent such change is approved by the Superintendent of [Insurance] Financial Services.

Section 51.4 is amended as follows:

Procedures designed to meet the purposes of this Part, that are approved in advance and determined by the Superintendent of [Insurance] Financial Services not to be detrimental to policyholders and contractholders, may be substituted for this Part by an insurer where no sales agency force is used and the application is solicited and received by the insurer by mail or under other methods that are without agent or broker involvement. Any procedures approved by the Superintendent of [Insurance] Financial Services prior to the effective date of this Part must be resubmitted for approval.

Section 51.5 (a) is amended as follows:

(a) obtain with or as part of each application a completed “Definition of Replacement” in a form prescribed by the Superintendent of [Insurance] Financial Services and signed by the applicant and the agent or broker and leave a copy of such form with the applicant for his or her records;

Section 51.5(c)(3) is amended as follows:

(3) present to the applicant, not later than at the time the applicant signs the application, the “IMPORTANT Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts” and a completed “Disclosure Statement” signed by the agent or broker in the form prescribed by the Superintendent of [Insurance] Financial Services and leave copies of such forms with the applicant for his or her records;

Section 51.6(b)(5) is amended as follows:

(5) submit quarterly reports within 30 days of the end of each quarter, beginning at the end of the first full calendar quarter after the effective date of this Part, to the Superintendent of [Insurance] Financial Services, indicating which insurers, if any, have failed to provide the information as required in paragraph (c)(2) of this section;

Section 51.6(e) is amended as follows:

(e) Both the insurer whose life insurance policy or annuity contract is being replaced and the insurer replacing the life insurance policy or annuity contract shall establish and implement procedures to ensure compliance with the requirements of this Part. These procedures shall include a requirement that all material be dated upon receipt. Such insurers shall also designate a principal officer specifically responsible for the monitoring and enforcement of these procedures. All insurers covered under this Part shall furnish the Superintendent of [Insurance] Financial Services with these procedures and the name and title of the designated principal officer by the effective date of this Part. Any changes in these procedures or the designated principal officer shall be furnished to the Superintendent of [Insurance] Financial Services within 30 days of such change.

Section 51.8 is amended as follows:

The forms set forth in Appendixes 10A, 10B, 10C and 11 of this Title are hereby approved for use as specified in this Part. The forms shall be set forth in at least 12-point type and shall be highlighted as indicated herein. Substantially equivalent forms may be adopted with the prior approval of the Superintendent of [Insurance] Financial Services.

Section 52.1(a) is amended as follows:

(a) Health insurance provides the mechanism through which most people purchase or pay for their health care. Good health care is facilitated by an insurance mechanism [which] that helps the consumer make an informed choice as to the best coverage available to meet [the] his or her health care needs [of himself and his] and those of his or her family.

Section 52.1(f) is amended as follows:

(f) Recognizing that, as part of the contract approval process, the Superintendent of [Insurance] Financial Services has a statutory duty to assure that health insurance benefits are reasonable in relation to the premiums charged, procedures and requirements for the filing of premium rates have been incorporated into this Part. One method of determining whether benefits are reasonable, in relation to the premium charged, is to determine the percentage of the premium collected [which] that is expected to be returned to all policy-holders in the form of benefits. This percentage of return is known as the expected loss ratio. In order to prevent the insurer from retaining an unreasonable percentage of the premiums collected for expenses, commissions and profit, minimum expected loss ratio standards have been established.

Section 52.1(k), (l), and (m) are amended as follows:

(k) The Medicare Catastrophic Coverage Act of 1988 made significant changes in the benefits provided under Medicare beginning January 1, 1989. The benefit changes [are] were phased in over a time period running through 1993. The [Superintendent of Insurance] superintendent [has] promulgated [new] minimum standards for Medicare supplement insurance [to be] that became effective in 1989. Minimum standards for 1990 [will be] were promulgated by the department in 1989 [after the superintendent has had an opportunity to review and evaluate suggestions and recommendations requested from consumers, other governmental agencies, providers and insurers concerning the appropriate level of Medicare supplement insurance minimum standards for 1990 and beyond].

(l) The Medicare Catastrophic Coverage Act of 1988 made significant changes in the benefits provided under Medicare beginning January 1, 1989. The benefit changes [are] were phased in over a time period running through 1993. The [Superintendent of Insurance] superintendent promulgated minimum standards for Medicare supplement insurance for 1989 and the Ninth Amendment to Insurance Regulation No. 62 [completes] completed changes in the minimum standards for Medicare supplement insurance necessary for compliance with the Medicare Catastrophic Coverage Act of 1988 and [addresses] addressed other areas of concern with respect to this type of insurance.

(m) As a result of the changes in the benefits provided under Medicare that were made pursuant to the Medicare Catastrophic Coverage Act of 1988, the [Superintendent of Insurance] superintendent promulgated new minimum standards for Medicare supplement insurance in the Eighth and Ninth Amendments to Insurance Regulation No. 62. In November, 1989, it became clear that Congress was considering action to repeal or modify the Medicare Catastrophic Coverage Act of 1988. Anticipating Congressional action, the [Superintendent of Insurance] superintendent promulgated the Twelfth Amendment to Insurance Regulation No. 62, which repealed the requirement that insurers notify existing Medicare supplement policy or certificate holders of changes in Medicare benefits resulting from the Medicare Catastrophic Coverage Act of 1988 and corresponding changes in Medicare supplement insurance benefits by December 1, 1989. The mailing of such notices would have been confusing and potentially misleading. At the close of the first session of the 101st Congress, Congress repealed provisions regarding Medicare benefits from the Medicare Catastrophic Coverage Act of 1988. The [Superintendent of Insurance] superintendent [has] promulgated the Thirteenth Amendment to Insurance Regulation No. 62 to establish [new] minimum standards for Medicare supplement insurance; to assure the orderly implementation and adjustment of Medicare supplement insurance benefits and premiums due to changes in the Federal Medicare program; to provide for the reasonable standardization of the coverage, terms and benefits of Medicare supplement insurance policies; to facilitate public understanding of such policies; to eliminate policy provisions [which] that may duplicate Medicare benefits; to provide notice to former insureds of an offer to reinstitute coverage; and to provide full disclosure of policy benefits and benefit changes.

Section 52.1(o) is amended as follows:

(o) As a result of the changes in the benefits provided under the Federal Medicare program that were made pursuant to the Medicare Catastrophic Coverage Act of 1988 and the Medicare Catastrophic Coverage Repeal Act of 1989, the [Superintendent of Insurance] superintendent promulgated new minimum standards for Medicare supplement insurance in the Eighth, Ninth, and Thirteenth Amendments to Insurance Regulation No.

62. In accordance with the Omnibus Budget Reconciliation Act of 1990, the [Superintendent of Insurance] superintendent [has] promulgated the Seventeenth Amendment to Insurance Regulation No. 62 to establish revised minimum standards for Medicare supplement insurance policies or certificates delivered or issued for delivery on or after May 1, 1992. Such revised minimum standards [are] were intended to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement insurance policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies [which] that may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosure in the sale of accident and health insurance coverages to persons eligible for Medicare.

Section 52.2(w) is amended as follows:

(w) State of New York Certified Surgical Fee Schedule means a schedule setting forth fees for surgery, expressed on a relative value scale as certified by the Commissioner of Health and promulgated by the [Superintendent of Insurance] superintendent.

Section 52.15(b)(8) is amended as follows:

(8) An insurer shall file its overinsurance rules with the [Insurance] Department of Financial Services. Overinsurance shall be deemed to exist when an insured has more than one specified disease policy or certificate for the same specified disease whether it is with the same or a different insurer. In no event may an insurer issue a specified disease policy or certificate to any person [which] that will result in that person being covered for eight or more specified diseases.

Section 52.16(m)(5)(i) and (iii) are amended as follows:

(5) Prior to obtaining access from the [department of insurance] Department of Financial Services to the registry information of sex offenders obtained from the New York State Division of Criminal Justice Services, a health maintenance organization or insurer shall execute a Nondisclosure Statement and Authorization Form as prescribed by the superintendent. The Nondisclosure Statement and Authorization Form shall be signed by an authorized officer of the health maintenance organization or insurer and shall contain the names of the persons in the employ of the health maintenance organization or insurer who are authorized to receive the information. By signing the form the authorized officer certifies that:

(i) the named employees of the health maintenance organization or insurer are authorized to receive information from the [department of insurance] Department of Financial Services regarding persons required to register as sex offenders;

(iii) the health maintenance organization or insurer will promptly notify the [department of insurance] Department of Financial Services of any relevant changes of persons in the employ of the health maintenance organization or insurer who are authorized to receive such information.

Footnote to Section 52.17(a)(34) is amended as follows:

42 United States Code 1395ss (2007) published by Office of Law Revision Counsel, United States House of Representatives. It is available from the New York State [Insurance] Department of Financial Services, Office of General Counsel, [25 Beaver] One State Street, New York, NY 10004.

Section 52.17(a)(35)(iv) is amended as follows:

(iv) the determination of appropriate medical candidates by the treating physician.

Said standards and guidelines are taken from The American Society for Reproductive Medicine's Practice Committee Opinions on The Definition of Experimental, The Definition of Infertility, The Guidelines for the Provision of Infertility Services and The Revised Minimum Standards for in In Vitro Fertilization, Gamete Intrafallopian Transfer and Related Procedures. These Practice Committee Opinions were approved by the Practice Committee of the American Society for Reproductive Medicine (Formerly The American Fertility Society) on March 27, 1993 and approved by the Board of Directors of the American Society for Reproductive Medicine (Formerly The American Fertility Society) on May 17, 1993. The Practice Committee Opinions can be obtained from The American Society for Reproductive Medicine Formerly The American Fertility Society 1209 Montgomery Highway, Birmingham, Alabama 35216-2809 and are available for public inspection and copying from The New York State [Insurance] Department of Financial Services at either [25 Beaver] One State Street, New York, New York 10004 or One Commerce Plaza, Albany, New York 12257.

Footnote to Section 52.18(a)(9) is amended as follows:

42 United States Code 1395ss (2007) published by Office of Law Revision Counsel, United States House of Representatives. It is available from the New York State [Insurance] Department of Financial Services, Office of General Counsel, [25 Beaver] One State Street, New York, NY 10004.

Section 52.18(a)(10)(iv) is amended as follows:

(iv) the determination of appropriate medical candidates by the treating physician. Said standards and guidelines are taken from The American Society for Reproductive Medicine's Practice Committee Opinions on The Definition of Experimental, The Definition of Infertility, The Guidelines for the Provision of Infertility Services and The Revised Minimum Standards for In Vitro Fertilization, Gamete Intrafallopian Transfer and Related Procedures. These Practice Committee Opinions were approved by the Practice Committee of the American Society for Reproductive Medicine (formerly The American Fertility Society) on March 27, 1993 and approved by the Board of Directors of the American Society for Reproductive Medicine (formerly The American Fertility Society) on May 17, 1993. The Practice Committee Opinions may be obtained from The American Society for Reproductive Medicine formerly The American Fertility Society, 1209 Montgomery Highway, Birmingham, AL 35216-2809 and are available for public inspection and copying from the New York State [Insurance] Department of Financial Services at either [25 Beaver] One State Street, New York, NY 10004 or One Commerce Plaza, Albany, NY 12257.

Section 52.21(i) is amended as follows:

(i) For any student blanket health insurance program not previously approved, a licensed insurer may bid on the risk subject to the approval of the Superintendent of [Insurance] Financial Services, but no solicitation or enrollment of students may be made prior to such approval.

Section 52.24(c)(1) is amended as follows:

(1) The report must be furnished to the superintendent by all commercial insurers, article 43 corporations and HMO's. Such report should be sent to the Superintendent of [Insurance] Financial Services, One Commerce Plaza, Albany, NY 12257.

Section 52.41(b)(2) is amended as follows:

(2) published credible experience, such as morbidity studies of the Society of Actuaries and the studies made by the Department of Financial Services or the former New York Insurance Department;

Section 52.42(b) is amended as follows:

(b) By use of an approved rider or remitting agent agreement an HMO may charge the current community rate, subject to a future increase or decrease to the premium. This rider may be applied to a group contract or group remittance arrangement where the group remitting agent agrees to accept liability for payments due to the HMO. Any such change to the premium should be debited or credited to a retroactive adjustment account. Settlement of the amount must occur no later than 12 months after the end of the prior contract year or upon termination of the contract, if earlier. A retrospective adjustment example:

Assume that there is agreement between the HMO and the employer that the rate previously approved by the [Insurance] Department of Financial Services of \$100 will be maintained for a year, subject to any subsequent adjustments. Six months later, the HMO receives the superintendent's approval for a premium rate increase, so that the new rate will be \$ 110. The employer continues to pay \$ 100 so that at the end of the year it would have underpaid by \$ 60. Upon renewal, its rate would be \$ 115 so that it will be covering the current approved rate of \$ 110 and will be paying off the \$ 60 shortfall under its renewal agreement.

Section 52.42(e) is amended as follows:

(e) Commissions or fees payable by health maintenance organizations to an insurance broker as authorized by 10 NYCRR Part 98. A health maintenance organization (HMO) issued a certificate of authority pursuant to article 44 of the Public Health Law, an HMO operated as a line of business of a health service corporation licensed under article 43 of the Insurance Law and having a certificate of authority pursuant to article 44 of the Public Health Law, or an HMO organized prior to the enactment of article 44 of the Public Health Law [which] that has a license from the Superintendent of [Insurance] Financial Services as a health service corporation pursuant to article 43 of the Insurance Law and a certificate of need as a health facility from the Commissioner of Health pursuant to article 28 of the Public Health Law, may, as authorized by 10 NYCRR Part 98, pay commissions or fees to a licensed insurance broker. Such authority to pay commissions or fees by a corporation, other than a corporation solely holding a certificate of authority from the Commissioner of Health,

shall be restricted to its HMO operation only. No licensed insurance broker shall receive such commissions or fees from an HMO, unless the HMO has filed the actual rate to be paid and included the anticipated expenses for such payments to insurance brokers in its application to amend its community premium rates pursuant to the provisions of section 4308 of the Insurance Law. Such rate shall be incorporated into the HMO's premium rate manual. The actual rate per annum may not exceed four percent of the HMO's approved premium for the contract sold.

Section 52.54(c)(2) is amended as follows:

(2) the appropriate disclosure statement or statements as follows:

(i) Basic hospital insurance. The insurance evidenced by this certificate meets the minimum standards for basic hospital insurance as defined by the New York State [Insurance] Department of Financial Services. It does NOT provide basic medical or major medical insurance.

(ii) Basic medical insurance. The insurance evidenced by this certificate meets the minimum standards for basic medical insurance as defined by the New York State [Insurance] Department of Financial Services. It does NOT provide basic hospital or major medical insurance.

(iii) Major medical insurance. The insurance evidenced by this certificate meets the minimum standards for major medical insurance as defined by the New York State [Insurance] Department of Financial Services. It does NOT provide basic hospital or basic medical insurance.

(iv) Limited benefits health insurance. The insurance evidenced by this certificate provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical, major medical, Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance as defined by the New York State [Insurance] Department of Financial Services.

(v) Disability income insurance. The insurance evidenced by this certificate provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State [Insurance] Department of Financial Services.

(vi) Accident insurance. The insurance evidenced by this certificate provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State [Insurance] Department of Financial Services. **IMPORTANT NOTICE-THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.**

Section 52.55 is amended as follows:

To comply with section 52.54 of this Part, policies of individual insurance meeting the standards of section 52.5 of this Part shall use the following statement only, except that appropriate policy identification may be included:

COMPANY NAME

BASIC HOSPITAL INSURANCE

REQUIRED DISCLOSURE STATEMENT

This policy meets the minimum standards for basic hospital insurance as defined by the New York State [Insurance] Department of Financial Services and pays * (, subject to _____** deductible,) (the semi-private room and board and miscellaneous hospital charges) (the semi-private room and board charges up to a maximum of \$_____ per day and miscellaneous hospital charges up to a maximum of \$_____) (_____% of the semi-private room and board charges) (\$_____ per day for room and board charges and miscellaneous hospital charges up to a maximum of \$_____) for not more than[.] _____days for each continuous hospital confinement, and outpatient hospital services for surgery and for accidental injury when performed within _____hours following accidental injury (up to a maximum of \$_____). This policy:

1. (is) (is not) renewable to eligibility for Medicare by reason of age.
2. (does not contain) (contains) special age limitations for coverage.
3. (is) (is not) subject to increases in premiums.
4. (does not limit) (limits) coverage for preexisting conditions.
5. (does not contain) (contains) probationary periods (for up to _____ days).
6. (does not cover) (covers) hospital charges for mental illness.
7. (does not cover) (covers) private duty nursing.
8. (does not cover) (covers) X-ray and laboratory tests as an admitted hospital outpatient.

This disclosure statement is a very brief summary of your policy.

The policy itself sets forth the rights and obligations of both you and the insurance company.

Policies frequently have special limits for pregnancy, mental illness, X-ray and laboratory tests when covered by the policy. All policies contain exclusions, which are not listed above. It is therefore important that you **READ YOUR POLICY** carefully.

This policy does NOT provide basic hospital or major medical insurance.

The expected benefit ratio for this policy is _____%. This ratio is the portion of future premiums [which] that the company expects to return as benefits, when averaged over all people with this policy.

* Use alternate parenthetical material where appropriate.

** Fill in blanks with appropriate material.

Section 52.56 is amended as follows:

To comply with section 52.54 of this Part, policies of individual insurance meeting the standards of section 52.6 of this Part shall use the following statement only, except that appropriate policy identification may be included:

COMPANY NAME

BASIC MEDICAL INSURANCE

REQUIRED DISCLOSURE STATEMENT

This policy meets the minimum standards for basic medical insurance as defined by the New York State [Insurance] Department of Financial Services and pays * (_____ % ** of the doctor's reasonable charges for anesthesia, in-hospital medical and surgical services.) (a maximum of \$_____ for surgery) (anesthesia up to _____ % of the surgical coverage) (in-hospital medical service up to \$_____ per day for _____ days.) (surgical, anesthetic and in-hospital medical service in full for persons whose income is below \$_____ per year.) (surgical, anesthetic and in-hospital medical services in full.) This policy:

1. (is) (is not) renewable to eligibility for Medicare by reason of age.
2. (does not contain) (contains) special age limitations for coverage.
3. (is) (is not) subject to increases in premium.
4. (does not limit) (limits) coverage for preexisting conditions.
5. (does not contain) (contains) probationary periods (for up to _____ days).
6. (does not cover) (covers) charges for mental illness.
7. (does not cover) (covers) X-ray and laboratory tests outside of a hospital.

This disclosure statement is a very brief summary of your policy.

The policy itself sets forth the rights and obligations of both you and the insurance company.

Policies frequently have special limits for pregnancy, mental illness, X-ray and laboratory tests when covered by the policy. All policies contain exclusions, which are not listed above. It is therefore important that you READ YOUR POLICY carefully.

This policy does NOT provide basic hospital or major medical insurance.

The expected benefit ratio for this policy is _____ %. This ratio is the portion of future premiums [which] that the company expects to return as benefits, when averaged over all people with this policy.

* Use alternate parenthetical material where appropriate.

** Fill in blanks with appropriate material.

Section 52.57 is amended as follows:

To comply with section 52.54 of this Part, policies of individual insurance meeting the standards of both sections 52.5 and 52.6 of this Part shall use the following statement only, except that appropriate policy identification may be included:

COMPANY NAME

BASIC HOSPITAL AND MEDICAL INSURANCE

REQUIRED DISCLOSURE STATEMENT

This policy meets the minimum standards for basic hospital insurance and basic medical insurance as defined by the New York State [Insurance] Department of Financial Services and pays * (, subject to a \$_____** deductible,) (the semi-private room and board and miscellaneous hospital charges) (the semi-private room and board charges up to a maximum of \$_____per day and miscellaneous hospital charges up to a maximum of \$_____) (_____% of the semi-private room and board charge) (\$_____per day for room and board charges and miscellaneous hospital charges up to a maximum of \$_____) for not more than _____days for each continuous hospital confinement, and outpatient hospital services for surgery and for accidental injury when performed within_____hours following accidental injury (up to a maximum of \$_____) and (_____% of the doctor's reasonable charges for anesthesia, in-hospital medical and surgical services.) (a maximum of \$_____for surgery) (anesthesia up to _____% of the surgical coverage) (in-hospital medical service up to \$_____per day for_____days.) (surgical, anesthetic and in-hospital medical service in full for persons whose insurance is below \$ _____per year.) (surgical, anesthetic and in-hospital medical services in full.) This policy:

1. (is) (is not) renewable to eligibility for Medicare by reason of age.
2. (does not contain) (contains) special age limitations for coverage.
3. (is) (is not) subject to increases in premium.
4. (does not limit) (limits) coverage for preexisting conditions.
5. (does not contain) (contains) probationary periods (for up to_____days).
6. (does not cover) (covers) hospital charges for mental illness.
7. (does not cover) (covers) medical charges for mental illness.
8. (does not provide) (provides) in-hospital medical services for mental illness.

- 9. (does not cover) (covers) private duty nursing.
- 10. (does not cover) (covers) X-ray and laboratory tests as admitted hospital outpatient.
- 11. (does not cover) (covers) X-ray and laboratory tests outside of a hospital.

This disclosure statement is a very brief summary of your policy.

The policy itself sets forth the rights and obligations of both you and the insurance company.

Policies frequently have special limits for pregnancy, mental illness, private duty nursing, outpatient care, X-ray and laboratory tests when covered by the policy. All policies contain exclusions, which are not listed above. It is therefore important that you READ YOUR POLICY carefully.

This policy does NOT provide major medical insurance.

The expected benefit ratio for this policy is _____%. This ratio is the portion of future premiums [which] that the company expects to return as benefits, when averaged over all people with this policy.

* Use alternate parenthetical material where appropriate.

** Fill in blanks with appropriate material.

Section 52.58 is amended as follows:

To comply with section 52.54 of this Part, policies of individual insurance meeting the standards of section 52.7 of this Part shall use the following statement only, except that appropriate policy identification may be included:

COMPANY NAME

MAJOR MEDICAL INSURANCE

REQUIRED DISCLOSURE STATEMENT

This policy meets the minimum standards for major medical insurance as defined by the New York State [Insurance] Department of Financial Services and pays for hospital and medical care subject to a copayment by you of _____% * and a deductible ** (equal to the benefits paid under other insurance or \$_____, whichever is greater) (equal to the benefits paid under other insurance plus \$_____) (of \$ _____per person) (of \$ _____per family) (of \$ _____per illness) (of \$ _____per benefit period) (of \$ _____per year) and a total maximum limit of \$ _____. (This policy defines “covered charges,” *** which has the effect of reducing the amount of the actual charges [which] that otherwise would be covered.) (Covered charges are limited to a maximum of \$ _____per day for hospital room and board.) (\$ _____ for miscellaneous hospital charges) (and \$ _____for surgery.) This policy:

1. (is) (is not) renewable to eligibility for Medicare by reason of age.
2. (does not contain) (contains) special age limitations for coverage.
3. (is) (is not) subject to increases in premium.
4. (does not limit) (limits) coverage for preexisting conditions.
5. (does not contain) (contains) probationary period (for up to _____ days).
6. (does not cover) (covers) hospital and medical charges for mental illness.
7. (does not cover) (covers) private duty nursing.
8. (does not cover) (covers) drugs and medicines.

This disclosure statement is a very brief summary of your policy.

The policy itself sets forth the rights and obligations of both you and the insurance company.

Policies frequently have special limits for pregnancy, mental illness, private duty nursing and drugs and medicines when covered by the policy. All policies contain exclusions, which are not listed above. It is therefore important that you READ YOUR POLICY carefully. This policy does NOT provide basic hospital or basic medical insurance. ****

The expected benefit ratio for this policy is _____. This ratio is the portion of future premiums [which] that the company expects to return as benefits, when averaged over all people with this policy.

* Fill in blanks with appropriate material.

** Use alternate parenthetical material where appropriate.

*** Insert appropriate reference if words such as “eligible expenses”, “compensable expenses”, etc., are used in the policy.

**** This sentence may be appropriately modified if policy also meets the definition for basic hospital or basic medical or deleted if policy meets the definition of both.

Section 52.59 is amended as follows:

(a) To comply with section 52.54 of this Part, policies of individual insurance [which] that are issued to persons who are less than 65 years of age and meet the definition of section 52.10 of this Part shall use the following statement only, except that appropriate policy identification may be included:

COMPANY NAME

LIMITED BENEFITS HEALTH INSURANCE

REQUIRED DISCLOSURE STATEMENT

This policy provides limited benefits health insurance ONLY. This policy does NOT provide basic hospital, basic medical or major medical insurance, as defined by the New York State [Insurance] Department of Financial Services.

(Accurately list benefits, exclusions, reductions and limitations of the policy in a manner [which] that does not encourage misrepresentation of the actual coverage provided.)

This disclosure statement is a very brief summary of your policy.

The policy itself sets forth the rights and obligations of both you and the insurance company. It is therefore imperative that you READ YOUR POLICY carefully.

The expected benefit ratio for this policy is _____%. This ratio is the portion of future premiums [which] that the company expects to return as benefits[,] when averaged over all people with this policy.

(b) To comply with section 52.54 of this Part, policies of individual insurance [which] that are issued to persons who are age 65 or older and meet the definition of section 52.10 of this Part shall use the following statement only, except that appropriate policy identification may be included:

COMPANY NAME

LIMITED BENEFITS HEALTH INSURANCE

REQUIRED DISCLOSURE STATEMENT

This policy provides limited benefits health insurance ONLY. This policy does NOT provide Medicare supplement insurance, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance as defined by the New York State [Insurance] Department of Financial Services. For information concerning Medicare supplement insurance, contact the New York State [Insurance] Department of Financial Services. You may also contact your local social security office or this company and request a copy of the Medicare supplement buyers' guide.

(Accurately list benefits, exclusions, reductions and limitations of the policy in a manner [which] that does not encourage misrepresentation of the actual coverage provided.)

This disclosure statement is a very brief summary of your policy.

The policy itself sets forth the rights and obligations of both you and the Insurance Company. It is therefore imperative that you READ YOUR POLICY carefully.

The expected benefit ratio for this policy is _____%. This ratio is the portion of future premiums [which] that the company expects to return as benefits[,] when averaged over all people with this policy.

Section 52.60 is amended as follows:

To comply with section 52.54 of this Part, policies of individual insurance meeting the definition of section 52.8 of this Part shall use the following statement only, except that appropriate policy identification may be included:

COMPANY NAME

DISABILITY INCOME INSURANCE

REQUIRED DISCLOSURE STATEMENT

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 [Insurance] Department of Financial Services. This policy:

(Accurately list benefits, exclusions, reductions and limitations of the policy in a manner [which] that does not encourage misrepresentation of the actual coverage provided.)

This disclosure statement is a very brief summary of your policy.

The policy itself sets forth the rights and obligations of both you and the Insurance Company. It is therefore important that you READ YOUR POLICY carefully.

The expected benefit ratio for this policy is _____%. This ratio is the portion of future premiums [which] that the company expects to return as benefits[,] when averaged over all people with this policy.

Section 52.61 is amended as follows:

To comply with section 52.54 of this Part, policies of individual insurance meeting the definition of section 52.9 of this Part shall use the following statement only, except that appropriate policy identification may be included:

COMPANY NAME

ACCIDENT INSURANCE

REQUIRED DISCLOSURE STATEMENT

This policy provides insurance only for ACCIDENTS. It does NOT provide basic hospital, basic medical or major medical insurance, as defined by the New York State [Insurance] Department of Financial Services.

IMPORTANT NOTICE--THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

This policy:

(Accurately list benefits, exclusions, reductions and limitations of the policy in a manner [which] that does not encourage misrepresentation of the actual coverage provided.)

This disclosure statement is a very brief summary of your policy.

The policy itself sets forth the rights and obligations of both you and the Insurance Company. It is therefore important that you READ YOUR POLICY carefully.

The expected benefit ratio for this policy is to _____%. This ratio is the portion of future premiums [which] that the company expects to return as benefits[,] when averaged over all people with this policy.

Section 52.65 is amended as follows:

In order to comply with section 52.54 of this Part, policies of individual insurance and certificates and policies of group insurance meeting the definition of section 52.12 or 52.13 of this Part shall use the following statement only, except that appropriate policy identification may be included.

(COMPANY NAME) (LONG TERM CARE INSURANCE) OR (NURSING HOME AND

[] HOME CARE INSURANCE) OR (NURSING HOME INSURANCE ONLY) OR (HOME CARE INSURANCE ONLY)

REQUIRED DISCLOSURE STATEMENT

(Policy Number or Group Master Policy and Certificate Number)

1. This policy or certificate is (an individual policy of insurance) (a group policy or certificate) [which] that was issued in the (indicate jurisdiction in which the policy or certificate was issued).

5. LONG TERM CARE INSURANCE. Policies or certificates of this category are designed to provide coverage for not less than twenty-four (24) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis and provides coverage of all levels of care in a nursing home and home care benefits. This policy or certificate provides coverage in the form of a fixed dollar indemnity benefit for covered long term care expenses, subject to policy or certificate (limitations) (waiting periods) and (coinsurance) requirements. (Modify this paragraph if the policy or certificate is not an indemnity policy or certificate.)

OR

NURSING HOME INSURANCE ONLY, HOME CARE INSURANCE ONLY, OR NURSING HOME AND HOME CARE INSURANCE. Policies or certificates of this category are designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis and provides at least custodial care services in a nursing home (and)(or) home care benefits. This policy or certificate provides coverage in the form of a fixed dollar indemnity benefit for covered expenses, subject to policy or certificate (limitations) (waiting periods) and (coinsurance) requirements. (Modify this

paragraph if the policy or certificate is not an indemnity policy or certificate.) THIS POLICY OR CERTIFICATE DOES NOT PROVIDE LONG TERM CARE INSURANCE AS THAT TERM IS DEFINED BY THE NEW YORK STATE [INSURANCE] DEPARTMENT OF FINANCIAL SERVICES. (If for a nursing home insurance only policy or certificate or a home care insurance only policy or certificate.) (THIS POLICY)(CERTIFICATE)(DOES NOT PROVIDE COVERAGE FOR NURSING HOME.) (THIS POLICY)(CERTIFICATE) (DOES NOT PROVIDE COVERAGE FOR HOME CARE.)

7. LIMITATIONS AND EXCLUSIONS.

(Describe:

- (a) Preexisting conditions;
- (b) Exclusions/exceptions;
- (c) Limitations.)

(This section should provide a brief specific description of any policy or certificate provisions [which] that limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.)

THIS POLICY OR CERTIFICATE MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

11. ADDITIONAL FEATURES.

(a) Nonforfeiture. Describe nonforfeiture benefits or state policy or certificate does not contain such benefits.

(b) Describe other important features.

(c) The expected benefit ratio for this policy or certificate is percent. This ratio is the portion of future premiums [which] that the company expects to return as benefits, when averaged over all people with this policy or certificate.

Section 52.66 is amended as follows:

(a) To comply with section 52.15 of this Part, policies of individual insurance and certificates and policies of group or blanket insurance meeting the definition of section 52.15 of this Part [which] that are issued to persons who are less than 65 years of age shall use the following statement only, except that appropriate policy and certificate identification may be included:

COMPANY NAME

SPECIFIED DISEASE COVERAGE ONLY

REQUIRED DISCLOSURE STATEMENT

This policy or certificate is (an individual policy of insurance) (a group or blanket policy or certificate). This policy or certificate provides specified disease coverage ONLY. This policy or certificate does NOT provide basic hospital, basic medical or major medical insurance, as defined by the New York State [Insurance] Department of Financial Services.

(Accurately list benefits, exclusions, reductions and limitations of the policy or certificate in a manner [which] that does not encourage misrepresentation of the actual coverage provided.)

This disclosure statement is a very brief summary of your policy or certificate.

The policy or certificate itself sets forth the rights and obligations of both you and the insurance company. It is therefore imperative that you READ YOUR POLICY OR CERTIFICATE carefully.

The expected benefit ratio for this policy or certificate is _____%. This ratio is the portion of future premiums [which] that the company expects to return as benefits, when averaged over all people with this policy or certificate.

(b) To comply with section 52.15 of this Part, policies of individual insurance and certificates and policies of group or blanket insurance meeting the definition of section 52.15 of this Part [which] that are issued to persons who are age 65 or older shall use the following statement only, except that appropriate policy and certificate identification may be included:

COMPANY NAME

SPECIFIED DISEASE COVERAGE ONLY

REQUIRED DISCLOSURE STATEMENT

This policy or certificate is (an individual policy of insurance) (a group or blanket policy or certificate). This policy or certificate provides specified disease coverage ONLY. This policy or certificate does NOT provide Medicare supplement insurance, long term care insurance, nursing home insurance only, home care insurance only or nursing home and

home care insurance as defined by the New York State [Insurance] Department of Financial Services. You may also contact your local social security office or this company and obtain a copy of the Guide to Health Insurance for People with Medicare.

(Accurately list benefits, exclusions, reductions and limitations of the policy or certificate in a manner [which] that does not encourage misrepresentation of the actual coverage provided.)

This disclosure statement is a very brief summary of your policy or certificate.

The policy or certificate itself sets forth the rights and obligations of both you and the insurance company. It is therefore imperative that you READ YOUR POLICY OR CERTIFICATE carefully.

The expected benefit ratio for this policy or certificate is _____%. This ratio is the portion of future premiums [which] that the company expects to return as benefits, when averaged over all people with this policy or certificate.

Section 53-3.7(b) is amended as follows:

(b) The illustration actuary shall certify that the disciplined current scale used in illustrations is in conformity with the Actuarial Standard of Practice No. 24 for Compliance with the NAIC Model Regulation on Life Insurance Illustrations promulgated by the Actuarial Standards Board, and that the illustrated scales used in insurer-authorized illustrations meet the requirements of this Subpart. A copy of Actuarial Standard of Practice No. 24 as adopted by the Actuarial Standards Board in December of 1995 may be obtained from the American Academy of Actuaries, 1100 Seventeenth Street NW, Washington, DC 20036 and a copy is available for public inspection at the [Insurance] Department of Financial Services' offices at One Commerce Plaza, Albany, NY and at [25 Beaver] One State Street, New York, NY and at the New York Department of State, 41 State Street, Third Floor, Albany, NY 12231.

Section 54.1(p) is amended as follows:

(p) Superintendent means the [Insurance] Superintendent of Financial Services of New York.

Section 54.1(y)(3) is amended as follows:

(3) is only available to an accredited investor, as defined in 17 CFR section 230.501(a)(2011),* or to a qualified purchaser, as defined in 15 U.S.C. section 80a-2(a)(51)(2010).** Copies of such documents are available for public inspection at the offices of the Department of Financial Services at One Commerce Plaza, Albany, New York 12257 and [25 Beaver Street] One State, New York, New York 10004.

Section 55.2(f)(2) is amended as follows:

(2) contracted with another insurer to replace the existing insurer for the providing of similar coverage for the same certificate holders, and filed an affidavit with the Commissioner of Labor and Superintendent of [Insurance] Financial Services to that effect.

(ii) Affidavits filed with the Superintendent of [Insurance] Financial Services shall refer to Labor Law, section 217 and this Part, and shall be addressed to: Chief, Health Bureau

New York State [Insurance] Department of Financial Services
One Commerce Plaza
Albany, NY 12257

Section 56.0 is amended as follows:

Section 52.16(c)(5) of Part 52 of this Title (Insurance Regulation 62), permits insurers and health maintenance organizations (HMOs) that are required to provide coverage for surgical services, to exclude coverage of cosmetic surgery. Part 52 does not define cosmetic surgery, but does provide examples of two types of reconstructive surgeries that may never be considered cosmetic. Subsequent to the promulgation of Part 52, Title I and Title II of Article 49 of the Insurance Law and Public Health Law were enacted that require medical necessity denials to be subject to utilization review and external appeal. The [Insurance] Department of Financial Services has found inconsistencies among insurers and HMOs as to when denials of surgery are considered medical necessity denials and subject to utilization review and external appeal. Section 56.3 of this Part and an amended section 52.16(c)(5) of Part 52 of this Title clarify that, whenever surgery is a covered benefit under certain policies, a determination that the surgery is cosmetic is a medical necessity determination subject to the utilization review and external review requirements of Titles I and II of Article 49 of the Insurance Law and Public Health Law, except in certain cases when the claim or request for surgery is identified by one of the codes in subdivision (f) of section 56.3 of this Part and is submitted without medical information.

Footnotes to Section 58.1 are amended as follows:

* 42 United States Code 1395ss (2007) published by the Office of Law Revision Counsel, United States House of Representatives. See www.gpoaccess.gov. It is available from the New York State [Insurance] Department of Financial Services, Office of General Counsel, [25 Beaver] One State Street, New York, NY 10004.

** Part 46 of Title 45, Code of Federal Regulations (2005) published by the Office of Law Revision Counsel, United States House of Representatives. See www.gpoaccess.gov. It is available from the New York State [Insurance] Department of Financial Services, Office of General Counsel, [25 Beaver] One State Street, New York, NY 10004.

*** Pub. L. 108-173. (2007) published by the Office of Law Revision Counsel, United States House of Representatives. See www.gpoaccess.gov. It is available from the New York State [Insurance] Department of Financial Services, Office of General Counsel, [25 Beaver] One State Street, New York, NY 10004.

Section 59.0(a) is amended as follows:

(a) One of the major provisions of chapter 369 of the Laws of 1985 requires approval of certificates by the Superintendent of [Insurance] Financial Services in accordance with section 3201(b)(1) of the Insurance Law when such certificates insure New York residents under a group insurance policy delivered outside of New York to a group [which] that, as of January 1, 1986, is a newly recognized group under New York law or is a group not specifically described in section 4216(b), 4235(c)(1) or 4237(a)(3) of the Insurance Law. This approval procedure was required to provide the basic protection of New York law and regulations to residents of this State when they purchase insurance coverage through out-of-state group arrangements where the individual insured has no close association or affiliation with the group policyholder.

Section 59.3(a)(1) is amended as follows:

(1) the insurer provides written certification to the [Insurance] Department of Financial Services that the certificates substantially comply with the standards applicable to group policies and certificates delivered in this State;

The introductory paragraph of section 60-1.6 is amended as follows:

This section implements Section 3420(a) and (g) of the Insurance Law, as amended by Chapter 584 of the Laws of 2002, which requires motor vehicle liability insurers to offer supplemental spousal liability (SSL) insurance to all policyholders in New York State who are covered under motor vehicle liability insurance policies that satisfy the requirements of Article 6 of the New York Vehicle and Traffic Law. This requirement applies to all policies issued or renewed that become effective on and after January 1, 2003. Section 3420(g)(2) provides that, pursuant to regulations promulgated by the Superintendent of [Insurance] Financial Services, a notification by the insurer to the insured shall include an explanation of the coverage and the insurer's premium for the coverage.

Paragraph 12 of sub-heading "Conditions" of the Prescribed SUM Endorsement in Section 60-2.3(f) is amended as follows:

CONDITIONS

12. Arbitration: If any insured making claim under this SUM coverage and we do not agree that such insured is legally entitled to recover damages from the owner or operator of an uninsured motor vehicle because of bodily injury sustained by the insured, or do not agree as to the amount of payment that may be owing under this SUM coverage, then, at the option and upon written demand of such insured, the matter or matters upon which such insured and we do not agree shall be settled by arbitration, administered by the American Arbitration Association, pursuant to procedures prescribed or approved by the Superintendent of [Insurance] Financial Services for this purpose.

If, however, the maximum amount of SUM coverage provided by this endorsement equals the amount of coverage required to be provided by section 3420(f)(1) of the New York Insurance Law and Article 6 or 8 of the New York Vehicle and Traffic Law, then such disagreement shall be settled by such arbitration procedures upon written demand of either the insured or us. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof, and any such insured and we each agree to be bound by any award made by the arbitrator as to this SUM coverage. For purposes of this Condition, the term “insured” includes any person authorized to act on behalf of the insured.

Section 60-2.4(b)(1) is amended as follows:

(b) Qualifications of arbitrators for a hearing held in New York State.

(1) Arbitrator screening committee. The superintendent shall appoint an advisory committee of six members, who will review the qualifications of applicants for the position of supplementary uninsured/underinsured motorists arbitrator for hearings to be held in New York State and review the performance of the appointed arbitrators. The screening committee shall make recommendations to the superintendent pertaining to the appointment and dismissal of SUM arbitrators. The committee shall consist of one representative of the New York State Bar Association, one representative of the New York State Trial Lawyers Association, two representatives of insurers, a nonvoting AAA representative and a nonvoting representative of the [Insurance] Department of Financial Services. Tie votes shall be reported as such to the superintendent.

Section 60-2.4 (e)(1) is amended as follows:

(e) Financing. (1) The cost of administering the AAA SUM arbitration forum shall be paid annually by insurers to the AAA upon receipt of a statement therefrom. This cost shall be distributed among insurers in an equitable manner approved by the Superintendent of [Insurance] Financial Services. This distribution shall, to the extent practicable, be a function of the degree to which an insurer is named as a respondent in AAA SUM arbitration proceedings.

Section 62-1.2 is amended as follows:

All renewal certificates issued in the State of New York shall conform with the foregoing provisions and may contain such additional features as may be approved upon filing with the Superintendent of [Insurance] Financial Services.

Section 62-2.3 is amended as follows:

Each insurer authorized to issue policies covering real or personal property located in this State against the peril of fire shall, upon the request of any law enforcement agency, investigative insurance organization engaged in loss prevention, tax district acting pursuant to the provisions of section 22 of the General Municipal Law, or governmental agency responsible for demolition of structures, release information in its possession resulting from an investigation conducted by it pertaining to such fire claim, including information as such agency, organization or district deems related to its own investigation. Should an insurer be of the opinion that the fire was caused by other than accidental means, the insurer shall so notify the appropriate law enforcement

agency or insurance organization engaged in loss prevention and the [Insurance Frauds Bureau] Criminal Investigations Unit of the [Insurance] Department of Financial Services of that opinion.

Section 62-2.4 is amended as follows:

In accordance with the provisions of section 318 of the Insurance Law, information reported to PILR pursuant to this Subpart shall be made available to law enforcement agencies, tax districts which have, pursuant to the provisions of section 22 of the General Municipal Law, filed with the superintendent a notice of intention to claim against the proceeds of a policy of fire insurance, and governmental agencies charged with the responsibility of demolition of structures. Requests for fire insurance loss information shall be submitted to the [Insurance Frauds Bureau] Department's Criminal Investigations Unit. The [Insurance Frauds Bureau] Criminal Investigations Unit shall transmit all such requests to PILR for processing. PILR shall furnish all available information compiled from reports required to be made by this Subpart, to the [Insurance Frauds Bureau] Criminal Investigations Unit, which in turn will make such information available to the requesting agency.

Section 62-4.0 is amended as follows:

The purpose of this Subpart is to implement the provisions of section 3403 of the Insurance Law [which] that require the Superintendent of [Insurance] Financial Services to promulgate a two-tier anti-arson application, [that] which includes certain questions [which] that shall be answered by the applicant for new or renewal insurance policies or binders covering the peril of fire or explosion, in addition to any further information that the insurer may require.

Section 62-4.1(c) is amended as follows:

(c) This Subpart applies to cities with a population of over 400,000 persons according to the 1970 census. However, the governing board of any local municipal corporation, as defined in article 1 of the General Municipal Law, may petition the Superintendent of [Insurance] Financial Services to mandate the use of the anti-arson application within specific designations in its jurisdiction for any policies issued 30 days after the superintendent's date of approval. Such petitions should be addressed to the:

Superintendent of [Insurance] Financial Services
New York State Department of [Insurance] Financial Services
Property [and Casualty Insurance] Bureau
[25 Beaver] One State Street
New York, NY 10004

Section 63.0(a) is amended as follows:

(a) Pursuant to the authority granted by what is now Section[s 201 and] 301 of the Insurance Law and Section 202 of the Financial Services Law, Part 63 was previously promulgated on February 15, 1980, and provided for standards for financial guaranty insurance of municipal bonds. These standards included the reserve requirements for such guaranties. Part 63 was subsequently amended, as an emergency rule, on April 22, 1986. The emergency rule was made permanent on June 19, 1986.

Section 64-1.0 is amended as follows:

Pursuant to the provisions of section 25.13 of the Parks, Recreation and Historic Preservation Law, policies of insurance providing liability insurance coverage to owners or operators of snowmobiles operating on the roadway or shoulder of a public street or highway in the State of New York must be in such language and form as shall be determined and established by the Superintendent of [Insurance] Financial Services.

Section 64-2.0 is amended as follows:

This Part implements section 2407 of article 48-C of the New York Vehicle and Traffic Law with respect to the requirement that an all-terrain vehicle (ATV) [which] that is operated anywhere in New York State, other than on the owner’s land, shall be covered by a policy of insurance[,] in such language and form as shall be determined and established by the Superintendent of [Insurance] Financial Services. Such policy shall provide for coverages required of an “owner’s policy of liability insurance” as set forth in section 311 of the Vehicle and Traffic Law.

Section 65-1.1(d) – (f) is amended as follows:

(d) Mandatory personal injury protection endorsement.

Section I

Arbitration. In the event any person making a claim for first-party benefits and the Company do not agree regarding any matter relating to the claim, such person shall have the option of submitting such disagreement to arbitration pursuant to procedures promulgated or approved by the Superintendent of [Insurance] Financial Services.

Section III

Constitutionality

If it is conclusively determined by a court of competent jurisdiction that the New York Comprehensive Motor Vehicle Insurance Reparations Act, or any amendment thereto, is invalid or unenforceable in whole or in part, then, subject to the approval of the Superintendent of [Insurance] Financial Services, the Company may amend this policy and may also recompute the premium for the existing or amended policy.

These amendments and recomputations will be effective retroactively to the date that such act or any amendment is deemed to be invalid or unenforceable in whole or in part.

* * *

(e) Mandatory personal injury protection endorsement - motorcycles.

Section I

Arbitration. In the event any person making a claim for first-party benefits and the Company do not agree regarding any matter relating to the claim, such person shall have the option of submitting such disagreement to arbitration pursuant to procedures promulgated or approved by the Superintendent of [Insurance] Financial Services.

Section III

Constitutionality

If it is conclusively determined by a court of competent jurisdiction that the New York Comprehensive Motor Vehicle Insurance Reparations Act, or any amendment thereto, is invalid or unenforceable in whole or in part, then, subject to the approval of the Superintendent of [Insurance] Financial Services, the Company may amend this policy and may also recompute the premium for the existing or amended policy.

These amendments and recomputations will be effective retroactively to the date that such Act or any amendment is deemed to be invalid or unenforceable in whole or in part.

* * *

(f) Mandatory personal injury protection endorsement - all-terrain vehicles (ATV).

Section I

Arbitration. In the event any person making a claim for first-party benefits and the Company do not agree regarding any matter relating to the claim, such person shall have the option of submitting such disagreement to arbitration pursuant to procedures promulgated or approved by the Superintendent of [Insurance] Financial Services.

Section III

Constitutionality

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These amendments and recomputations will be effective retroactively to the date that such Act or any amendment is deemed to be invalid or unenforceable in whole or in part.

* * *

Section 65-1.2(b) is amended as follows:

(b) The insurer shall in connection with new policy applications offer applicants OBEL coverage by sending the applicant the following letter:

Dear Applicant:

Basic No-Fault, which you are required by law to purchase, provides coverage of up to \$50,000 per person in benefits for:

1. all necessary doctor and hospital bills and other health service expenses, payable in accordance with fee schedules established or adopted by the New York State [Insurance] Department of Financial Services; and

Section 65-1.3(c) is amended as follows:

(c) *Additional personal injury protection endorsement.*

Arbitration

In the event any person making a claim for additional first-party benefits and the Company do not agree regarding any matter relating to the claim, such person shall have the option of submitting such disagreement to arbitration pursuant to procedures promulgated or approved by the Superintendent of [Insurance] Financial Services.

Section 65-1.8(c) is amended as follows:

(c) Any other unauthorized insurer may file with the Superintendent of [Insurance] Financial Services a statement that its automobile insurance policies sold in any other state or Canadian province will be deemed to

satisfy the financial security requirements of article 6 or 8 of the New York Vehicle and Traffic Law, and will be deemed to provide for the payment of first-party benefits pursuant to section 5103 of the New York Insurance Law when the insured motor vehicle is used or operated in this State.

Section 65-3.9(c) is amended as follows:

(c) If an applicant does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to [Insurance] Department of Financial Services regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken. If any applicant is a member of a class in a class action brought for payment of benefits, but is not a named party, interest shall not accumulate on the disputed claim or element of claim until a class [which] that includes such applicant is certified by court order, or such benefits are authorized in that action by Appellate Court decision, whichever is earlier.

Section 65-3.10(b) is amended as follows:

(b) If a dispute is resolved in accordance with any of the optional arbitration procedures contained in this Part, either during the initial review by the [Insurance] Department of Financial Services or by an arbitration award, and if payment is not made by the insurer in accordance with the terms specified in the conciliation letter or arbitration award within 45 days following such resolution, an additional attorney's fee shall be paid by the insurer when the attorney writes to the insurer in order to receive such overdue payment. The additional attorney's fee shall be \$60 and shall become payable only after written request from the attorney to the insurer, received by the insurer more than 45 days after mailing of the conciliation letter or arbitration award. Such fee shall not be payable if payment was made by the insurer prior to the attorney's request for such payment or if an arbitration award is appealed in accordance with the provisions of this Part.

Section 65-4.2(a)(1) is amended as follows:

(a) *Administration by an organization designated by the Superintendent.* (1) Section 5106 of the Insurance Law requires that the Superintendent of [Insurance] Financial Services promulgate simplified procedures for the resolution by arbitration of no-fault disputes.

Section 65-4.2(c)(1) is amended as follows:

(c) *Financing.* (1) The cost of administering the conciliation function, reduced by any fees collected, shall be paid annually by insurers (including self-insurers and MVAIC) to the designated organization upon receipt of a statement therefrom. This cost shall be distributed among insurers in an equitable manner approved by the Superintendent of [Insurance] Financial Services. This distribution shall, to the extent practicable, be a function of the degree to which an insurer is named as a respondent in conciliation proceedings of the designated organization.

Section 65-4.5(a) is amended as follows:

(a) *Notice.* If a dispute has been transmitted for arbitration by the [Insurance] Department of Financial Services or the conciliation center, the parties will be notified by the designated organization, in writing, that the dispute will be resolved by arbitration. At the arbitrator's discretion, if the dispute involves an amount less than

\$ 2,000, the parties shall be notified that the dispute shall be resolved on the basis of written submissions of the parties. All such submissions shall be received by the designated organization within 30 calendar days of the date of mailing of the notice. No oral arguments will be permitted, unless the arbitrator determines that additional evidence or testimony is necessary. In order to facilitate receipt of evidence by the designated organization, the parties may forward their submissions prior to receipt of the above notification.

Section 65-4.5(b)(9) is amended as follows:

(9) For the purpose of special expedited arbitration, the superintendent may appoint arbitrators, qualified in accordance with the provisions of this section, to serve on a per diem basis. Such arbitrators shall contract with the designated organization. The rate of per diem compensation shall be determined by the designated organization, after consultation with the no-fault arbitrator screening committee subject to the approval of the superintendent. Such arbitrators shall be independent contractors, and shall not be employees or agents of the designated organization or the [Insurance] Department of Financial Services.

Section 65-4.5(d)(1) is amended as follows:

(d) *Qualifications of arbitrators for a hearing held in New York State.* (1) No-Fault arbitrator screening committee. The superintendent shall appoint an advisory committee composed of six members, who will review the qualifications of applicants for the position of no-fault arbitrator for hearings to be held in New York State and review the performance of the appointed arbitrators. The screening committee shall make recommendations to the superintendent pertaining to the appointment and dismissal of no-fault arbitrators. The committee shall consist of one representative of the New York State Bar Association, one representative of the New York State Trial Lawyer's Association, two representatives of the insurance industry selected by the No-Fault Optional Arbitration Advisory Committee, a nonvoting representative of the designated organization and a nonvoting representative of the [Insurance] Department of Financial Services. Tie votes shall be reported as such to the superintendent.

Section 65-4.5(g) is amended as follows:

(g) *Conflict of interest and disqualification of arbitrator.* No person shall serve as an arbitrator in any arbitration in which such person has any financial or personal interest or bias. If a party challenges an arbitrator, the specific grounds for the challenge shall be submitted in writing to the designated organization, which shall determine, in consultation with the [Insurance] Department of Financial Services, within 15 calendar days after receipt of the challenge, whether the arbitrator shall be disqualified. Such written determination, in a format approved by the Department, shall be final and binding. If an arbitrator should resign, be disqualified or be otherwise unable to perform necessary duties, the designated organization shall assign another arbitrator to the case.

Section 65-4.5(s) is amended as follows:

(s) *Form and scope of award.* The award shall be in writing in a format approved by the superintendent. It shall state the issues in dispute and contain the arbitrator's findings and conclusions based on the Insurance Law and Insurance [Department] regulations. It shall be signed by the arbitrator and shall be transmitted to the parties by the designated organization with a copy to the [Insurance] Department of Financial Services. The

award shall contain a decision on all issues submitted to the arbitrator by the parties. In the event that the applicant prevails in whole or in part on the claim, the arbitrator shall also direct the insurer to:

Section 65-4.5(u)(1) is amended as follows:

(u) *Award upon settlement.* (1) If the parties settle their dispute during the course of arbitration, the arbitrator shall set forth the terms of the agreed settlement in an award, which shall provide that the parties agree that the settlement is final and binding and shall not be subject to review by a master arbitrator or by a court. If an attorney's fee is due under section 5106 of the Insurance Law, such fee shall be awarded in accordance with the limitations set forth in section 65-4.6 of this subpart. The award shall be signed by the arbitrator and shall be transmitted to the parties by the designated organization, with a copy to the [Insurance] Department of Financial Services.

Section 65-4.5(z) and (aa)(1) are amended as follows:

(z) *Arbitrator's compensation and expenses.* At the direction of the Superintendent, arbitrators shall contract on an annual basis with the designated organization. The rate of annual compensation shall be determined by the designated organization, after consultation with the No-Fault Arbitrator Screening Committee subject to the approval of the Superintendent. Arbitrators shall be independent contractors, and shall not be employees or agents of the designated organization or the [Insurance] Department of Financial Services.

(aa) *Financing.* (1) The cost of administering the No-Fault Arbitration forum shall be paid annually by insurers (including self-insurers and MVAIC) to the designated organization upon receipt of a statement therefrom. This cost shall be distributed among insurers in an equitable manner approved by the Superintendent of [Insurance] Financial Services. This distribution shall, to the extent practicable, be a function of the degree to which an insurer is named as a respondent in No-Fault Arbitration forum proceedings.

Section 65-4.6(g) is amended as follows:

(g) If a dispute involving an overdue or denied claim is resolved by the parties after it has been forwarded by the [Insurance] Department of Financial Services or the conciliation center to the appropriate arbitration forum or after a court action has been commenced, the claimant's attorney shall be entitled to a fee [which] that shall be computed in accordance with the limitations set forth in this section.

Section 65-4.10(e)(1)(i) is amended as follows:

(i) The award shall be in writing in a format approved by the superintendent. It shall state the issues in dispute and contain the master arbitrator's findings and conclusions based on the materials submitted. It shall be signed by the master arbitrator and shall be transmitted to the parties by the designated organization, with a copy to the [Insurance] Department of Financial Services. The award shall be determinative of all issues submitted to the master arbitrator by the parties.

Section 65-4.10(e)(2) is amended as follows:

(2) Award upon settlement. If the parties settle their dispute during the course of the master arbitration, the master arbitrator shall set forth the terms of the agreed settlement in an award, which shall provide that the parties agree that the settlement is final and binding and shall not be subject to review by a court or the subject of a de novo court action. The award shall be signed by the master and shall be transmitted to the parties by the designated organization, with a copy to the [Insurance] Department of Financial Services.

Section 66.0(d) is amended as follows:

(d) The bond form is usually needed immediately. The time required to file a new form and to obtain approval of the [Insurance] Department of Financial Services would severely inhibit the traditional use of surety bonds and cause principals and obligees to turn to other forms of security. The immediate need for such forms makes it impracticable to have them filed and approved prior to their use. Compliance with the requirement under Section 2307(b) of the Insurance Law would also result in an inordinate number of filings of surety bond forms [which] that are tailor-made to meet the specific needs of individual insureds.

Section 67.0(b) is amended as follows:

(b) It shall be the responsibility of every insurer [which] that issues and delivers automobile physical damage insurance in this State and of the New York automobile insurance plan (“the plan”) to establish and maintain inspection procedures [which] that fully comply with section 3411, as implemented by the provisions of this Part. On or before December 1, 1977, each such insurer and the plan shall file with the Superintendent of [Insurance] Financial Services, for his review, a statement describing in detail its plan of operation for establishing and adequately maintaining an inspection system. Any amendments to the plan of operation shall take effect upon filing with the superintendent. Failure to adhere to the provisions of section 3411 and this Part shall subject the violator to the penalty provisions of the Insurance Law, including section 3411(n).

Section 67.1(g) and (h) are amended as follows:

(g) *Inspection service* means any person or legal entity registered with the [Insurance] Department of Financial Services to perform the inspections required by this Part. Such inspection service shall maintain a record of the name, address and signature of all persons authorized by such service to perform the required inspection prior to such person performing any inspection pursuant to this Part.

(h) *Authorized representative* means, in this State, any person, legal entity or inspection service, other than the insured, licensed or registered in any capacity by the New York [Insurance] Department of Financial Services or, outside of this State, any person or legal entity, other than the insured, licensed or registered by the insurance department of the state in which the inspection will be conducted. All authorized representatives must be designated in writing by the insurer. The competency and trustworthiness of the authorized representative in the conduct of the inspection provided for in this Part shall be the responsibility of the insurer.

Section 67.9(a) is amended as follows:

(a) For all policies providing automobile physical damage coverage issued or renewed to be effective on and after December 1, 1977, insurers may adopt any one of the following procedures:

(1) amend the policy by adding thereto the endorsements as set out in subdivisions (c) and (d) of this section, which are hereby deemed approved upon filing with the [Insurance] Department of Financial Services;

(2) submit for [Insurance] Department of Financial Services approval the insurer's own substantively similar endorsements; or

(3) submit for [Insurance] Department of Financial Services approval the insurer's basic policy form incorporating the substance of the endorsement set out in subdivision (c) of this section.

Section 67.9(c)(1) is amended as follows:

(1) The company or its authorized representative has the right to inspect any private passenger automobile, including a nonowned automobile, insured or intended to be insured under this policy before physical damage coverage shall be effective, except to the extent that this right is prescribed and limited by [New York State] Insurance [Department] Regulation No. 79 (11 NYCRR Part 67) implementing section 3411 of the New York Insurance Law.

Section 67.9(d)(1) is amended as follows:

(1) a completed "Certification of Automobile Repairs" as prescribed by the New York State [Insurance] Department of Financial Services;

Section 67.10 is amended as follows:

(a) The [Insurance] Department of Financial Services has determined that it is reasonable for insurers to give premium reductions when an inspection made pursuant to this Part discloses that previous damage or prior condition of the automobile would result in a reduction in the amount payable for settlement of an automobile physical damage claim in the event of a total loss. Insurers may file revised premium rates, which would be effective under such circumstances, to reduce their fire, theft or comprehensive premium rates as follows:

<i>Diminution of Value</i>	<i>Reduction Permitted</i>
Under \$ 500	None
\$ 501 - 750	5 %
\$ 751 - 1,000	7½%
\$ 1,001 or more	10%

(b) The [Insurance] Department of Financial Services will approve rate filings containing the foregoing reductions. Insurers may offer greater reductions than those shown above, upon filing such proposed reductions for department review.

Section 68.0(d) is amended as follows:

(d) The Superintendent of [Insurance] Financial Services is required, after consulting with the chairman of the Workers' Compensation Board and the Commissioner of Health, to promulgate rules and regulations implementing and coordinating the Comprehensive Automobile Insurance Reparations Act and the Workers' Compensation Law regarding the charges for other professional health services, including the establishment of schedules for all such services for which schedules have not been prepared and established by the chairman of the Workers' Compensation Board.

Section 68.1(a) is amended as follows:

(a) The existing fee schedules prepared and established by the chairman of the Workers' Compensation Board for industrial accidents are hereby adopted by the Superintendent of [Insurance] Financial Services with appropriate modification so as to adapt such schedules for use pursuant to the provisions of section 5108 of the Insurance Law.

Section 68.2(a) is amended as follows:

(a) After consultation with the chairman of the Workers' Compensation Board and the Commissioner of Health, the Superintendent of [Insurance] Financial Services hereby establishes fee schedules for professional health services referred to in section 5102(a)(1) of the Insurance Law, and for which schedules have not been prepared and established by the chairman of the Workers' Compensation Board. The schedules for such professional health services, hereby adopted by the Superintendent of [Insurance] Financial Services, are incorporated herein as Appendix 17-C and charges for services listed therein shall not exceed the charges permissible under such schedules.

Section 68.8(a) is amended as follows:

(a) Insurers shall report any pattern of overcharging, excessive treatment or any other improper actions by a health provider, within 30 days after such insurer has knowledge of such pattern to the No-Fault Unit, Property Bureau, New York State [Insurance] Department of Financial Services, [25 Beaver] One State Street, New York, NY 10004, and to the following:

Section 70.1(c)(3) is amended as follows:

(3) a policy [which] that contains a provision concerning the consent of the insured, which has been approved by the [Insurance] Department of Financial Services as being consistent with the intention of this subdivision.

Section 70.1(m) is amended as follows:

(m) *Purchasing group* means any group formed pursuant to the Federal Liability Risk Retention Act of 1986 (LRRRA) (15 USC 3901 et seq.) (published by the U.S. Government Printing Office, Washington, D.C. Copies may be obtained by writing to the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. In addition, copies are available for viewing and copying at the New York State

[Insurance] Department of Financial Services, [25 Beaver] One State Street, New York, NY 10004 and at the Albany Office of the Secretary of State, 41 State Street, Albany, NY 12231) and:

Section 70.5(b)(2) is amended as follows:

(2) The superintendent has drawn upon casualty actuarial studies of similar legislative proposals, consulted with attorneys and other persons expert in medical malpractice litigation, and conferred on the implications of chapter 294 with the professional staffs of the [Insurance] Department of Financial Services, the Legislature and the Governor.

Section 70.7(c)(1) is amended as follows:

(c) (1) The superintendent has drawn upon existing casualty actuarial rate-making analyses and studies, testimony and evidence at [Insurance] Department of Financial Services hearings, consulted with attorneys and other persons expert in medical malpractice litigation, and conferred with the professional staffs of the [Insurance] Department of Financial Services, the Legislature and the Governor. Recognizing the above-described difficulties in excess coverage rate-making and the provisional nature of the excess rates being promulgated, the superintendent has concluded that the following provisional excess rates shall apply for the period July 1, 1985 through November 30, 1985 to excess coverages purchased by physicians and excess coverages purchased by general hospitals on behalf of their eligible physicians pursuant to section 19 of chapter 294:

Section 70.9(l) is amended as follows:

(l) *Segregated and surcharge accounts report form.*

NEW YORK STATE
[INSURANCE] DEPARTMENT OF FINANCIAL SERVICES
MEDICAL MALPRACTICE
REPORT OF SEGREGATED AND SURCHARGE ACCOUNTS

Insurer _____ NAIC Company Code _____

This report includes all activity during the twelve months ending June 30, [19] 20 _____ for the policy year beginning July 1, [19] 20 _____

Section 70.9(m) is amended as follows:

(m) Report of segregated and surcharge accounts instructions.

NEW YORK STATE
[INSURANCE] DEPARTMENT OF FINANCIAL SERVICES
MEDICAL MALPRACTICE

REPORT OF SEGREGATED AND SURCHARGE ACCOUNTS INSTRUCTIONS

A separate report shall be submitted as of every fiscal year (12 month period) ending June 30 for each policy year under stabilized rates. The first report should include all activity in all fiscal years up to and including the fiscal year ending June 30, 1988. Dollars reported are premiums written, expenses paid, and losses and allocated loss adjustment expenses paid during the fiscal year for the appropriate policy year, or losses and loss adjustment expenses outstanding (including IBNR) as of the end of the fiscal year. All dollars are direct, that is before application of any reinsurance ceded or assumed. The first report is due April 28, 1989. Subsequent reports are due in the [Insurance] Department of Financial Services on or before October 1, of each year and should be submitted to the following address:

Preparation & Analysis Unit
Property [& Casualty Insurance] Bureau[, 13th Floor]
New York State [Insurance] Department of Financial Services
[25 Beaver] One State Street
New York, New York 10004

Instructions by line

1) The account balance reported on line 9 of the previous fiscal year's submission for this same policy year should be included here. If the account balance does not agree with the previous year's submission a reconciliation must be submitted.

2) The direct written premium shall include premium written during the current fiscal year for the policy year being reported only. Ceded reinsurance premiums should not be subtracted nor assumed reinsurance premiums added. Premiums should be gross of all expenses. Surcharge amounts shall be included in the fiscal year report representing the period when the revenue is transferred from the surcharge account. Surcharge revenue cannot be transferred unless the account balance (line 9) falls below \$1,000,000 and then only enough surcharge revenue to permit an account balance of between \$1,000,000 and \$1,500,000 may be transferred. The total should be the sum of the direct written premium and the surcharge revenue.

3) Acquisition expenses should be those expenses paid as a percentage of premium including commissions to agents, attorney-in-fact and managing general agent fees, and premium taxes. Support for the amount of acquisition expenses included must be attached to this submission.

4) Overhead expenses paid should include general expenses, acquisition expenses not included above, and licenses and fees not included above. Support for the amount of overhead expenses included must be attached to this submission.

Note: All expenses must be allocated per [Insurance] Department of Financial Services

Section 71.0(a) is amended as follows:

(a) Prior to the original promulgation of this Part in 1983, the [Insurance] Department of Financial Services had approved a limited number of personal injury and property damage liability insurance policies in which legal defense costs were permitted to reduce the stated limits of liability when such legal defense costs were incident to a claim of legal liability covered under the policy. Further, the department had also approved certain policies that permitted legal defense costs to be applied against the deductible.

Section 72.1(a) is amended as follows:

(a) Section 727(a)(3) of the Business Corporation Law (B.C.L.), section 727(a)(3) of the Not-for-Profit Corporation Law (N-PCL) and section 7024(a)(3) of the Banking Law (B.L.) give a corporation the power to obtain insurance for the purpose of indemnifying its directors and officers in instances in which they may not otherwise be indemnified by the corporation under the provisions of B.C.L. article 7, N-PCL article 7 and B.L. title 7, provided that the contract of insurance indemnifying such corporate directors and officers, or “D&O indemnification policy.” includes a retention amount (or deductible) and coinsurance, in a manner acceptable to the Superintendent of [Insurance] Financial Services.

Section 73.0(b) and (c) are amended as follows:

(b) Following a public hearing on the Commercial General Liability (CGL) claims-made policy form proposed for general application by the Insurance Services Office, Inc. (ISO), and after evaluation of information received as a result of numerous meetings and communications with all interested parties, the [Insurance] Department of Financial Services issued an opinion and decision dated October 11, 1985 disapproving the proposed policy form and related endorsements for use in this State. Additional modifications thereafter submitted by ISO have been carefully analyzed by the department, which, however, reaffirmed its disapproval of the claims-made policy form approach for CGL purposes.

(c) The [Insurance] Department of Financial Services finds that claims-made coverage tends to provide less protection than occurrence coverage, that claims-made coverage compared to occurrence coverage is a more complicated and confusing method of coverage that can create potential coverage gaps and that, on balance, across-the-board application of the claims-made policy form for all types of liability coverages would be an unwarranted and inappropriate change in the traditional insurance system and, therefore, not in the public interest.

Section 74.1(b) is amended as follows:

(b) Every homeowner’s and dwelling fire personal lines policy containing a hurricane deductible shall be accompanied by a policyholder notice, [to be] which has been filed with the [Insurance] Department of Financial Services[,] and [which shall contain] contains the following minimum information:

Section 81-1.1(f)(1) is amended as follows:

(1) current statements of assets, liabilities, surplus and other funds if not then on file with the [Insurance] Department of Financial Services;

Section 83.2(g)(4) is amended as follows:

(4) It is the superintendent's intention to update this Part each year in order to adopt the newly published accounting manual, subject to such exceptions (as set forth in section 83.4 of this Part) as may be appropriate because of New York law or policy. If it becomes necessary for the superintendent to apprise the public and the insurance industry of new information regarding accounting practices prior to the next updating of this Part, the superintendent may issue circular letters to provide advice and instruction, or the superintendent may amend this Part as appropriate. Such information will also be included on the [Insurance Department's] Department of Financial Services website under "codification developments."

Section 83.3(c) is amended as follows:

(c) Except as provided in section 83.4 of this Part or where the accounting manual conflicts with any provision of the Insurance Law or this Title, the accounting manual is adopted in its entirety, subject to such conflicts and exceptions, and an insurer shall follow the accounting practices and procedures prescribed by the accounting manual. The accounting manual does not preempt States' legislative or regulatory authority. The accounting manual is intended to establish a comprehensive basis of accounting to be adhered to if not in conflict with the State statutes or regulations, or when the State statutes or regulations are silent. The accounting manual may also be viewed at the New York State [Insurance Department's] Department of Financial Services New York City office at [25 Beaver] One State Street, New York, NY 10004.

Section 83.4(q) is amended as follows:

(q) Paragraph 9 of SSAP No. 73 "Health Care Delivery Assets - Supplies, Pharmaceutical and Surgical Supplies, Durable Medical Equipment, Furniture, Medical Equipment and Fixtures, and Leasehold Improvements in Health Care Facilities" is not adopted. Durable medical equipment, furniture, medical equipment and fixtures, and leasehold improvements shall be depreciated utilizing a depreciation schedule no less conservative than that set forth in the latest revision of Estimated Useful Lives of Depreciable Hospital Assets (Revised 2004 Edition). The document may also be viewed at the New York State [Insurance Department's] Department of Financial Services New York City office at [25 Beaver] One State Street, New York, NY 10004. Lease improvements in health care facilities shall be amortized against net income over the shorter of their estimated useful life or the remaining life of the original lease excluding renewal or option periods, using methods detailed in SSAP No. 19.

Section 84.1(c) is amended as follows:

(c) Such registration statements and reports to stockholders containing financial statements on a GAAP basis shall also contain the following statement in bold face type on the first page on which a GAAP statement is first presented: "The New York State [Insurance] Department of Financial Services recognizes only statutory accounting practices for determining and reporting the financial condition and results of operations of an insurance company, for determining its solvency under the New York Insurance Law, and for determining whether its financial condition warrants the payment of a dividend to its stockholders. No consideration is given by the Department to financial statements prepared in accordance with generally accepted accounting principles in making such determinations". The statement shall also refer to the discussion of the principal

differences between statutory accounting practices and GAAP contained in the accountant's notes to the financial statements.

The title to Part 86 is amended as follows:

REPORTS OF SUSPECTED INSURANCE FRAUDS TO [INSURANCE FRAUDS BUREAU] CRIMINAL INVESTIGATIONS UNIT; REQUIRED WARNING STATEMENTS

Section 86.4(e) is amended as follows:

(e) Notwithstanding the provisions of subdivisions (a) and (b) of this section, insurers may use substantially similar warning statements provided such warning statements are submitted to the [Insurance Frauds Bureau] Criminal Investigations Unit for prior approval.

Section 86.5 is amended as follows:

Any person licensed pursuant to the provisions of the Insurance Law who determines that an insurance transaction or purported insurance transaction appears to be fraudulent or suspect shall submit a report thereon to the [Insurance Frauds Bureau] Criminal Investigations Unit. Reports shall be submitted on the prescribed reporting form issued by the [Insurance Frauds Bureau] Criminal Investigations Unit or upon any other form approved by order of the superintendent. Reporting may also be done by means of any electronic medium or system approved by order of the superintendent.

STATE OF NEW YORK
[INSURANCE] DEPARTMENT OF FINANCIAL SERVICES
[INSURANCE FRAUDS BUREAU] CRIMINAL INVESTIGATIONS UNIT REPORTING FORM

DATE _____

To:

State of New York
[Insurance] Department of Financial Services
[Frauds Bureau] Criminal Investigations Unit
[60 West Broadway] One State Street
New York, NY [10013] 10004

(1) Information furnished by:

Company
Name:

Address:

NAIC #

PLEASE PRINT/TYPE INFORMATION

(2) Brief statement of suspect transaction and dollar amount of claim:

(3) Identify parties to suspect transaction (name, address and relation to transaction):

(4) Identify your policy, claim or reference number under which the above transaction is recorded:

(5) Name, title, address and telephone number of individual in your company who can provide detailed information:

Name	Title	Address	Tel.#
------	-------	---------	-------

(6) Have you reported this transaction to any other law enforcement agency? _____

If yes, furnish name of agency, address, person contacted, date of report and telephone #.

Signed: _____

Title: _____

IFB-1

UNITED STATES DEPARTMENT OF JUSTICE
INSURANCE RELATED CRIMINAL REFERRAL FORM

To Be Used for Criminal Referrals in Suspected Cases of Major Insurance Fraud or Corruption.* Please provide as much of the requested information as possible, but if any information is unavailable leave the answer blank.

1. Name and Location of Insurance Company/Agency/Entity

Name _____

Location _____ street _____ city _____ state _____ zip _____

Location of Suspected Offense:

2. Asset Size of Insurance Company/Agency/Entity _____

3. Approximate date and dollar amount of loss due to suspected violation.

Date _____ Amount _____

Month Year

*Major insurance fraud or corruption is defined as: (1) a scheme [which] that resulted in a loss to the state, company, policyholders, a multiple employer trust (MET), a multiple employer welfare arrangement (MEWA), or participants in METs or MEWAs of more than \$100,000 or a gain to the perpetrator of more than \$100,000, or (2) insurance-related public corruption, such as bribery of a public official, regardless of the amount. Please exclude all arson cases or matters. In the event a fraud is uncovered [which] that involves less than \$100,000, this form may still be submitted or a referral may be made by letter.

4. Summary characterization of the suspected violation. Check appropriate item(s).

- | | |
|---|--------------------------------------|
| _____ Defalcation/embezzlement | _____ Employee Benefit Plans (ERISA) |
| _____ False Statement by insurance company (e.g. assets/liabilities; ownership; reserves) | _____ METS & MEWAS |
| _____ Misuse of Position or Self Dealing; other abuses by insurance company insiders | _____ Reinsurance |
| _____ Check Kiting | _____ Tax Violations |
| _____ Bank Fraud | _____ Public Corruption/Bribery |
| _____ Bank Secrecy Act/Money Laundering | _____ Securities Fraud |
| | _____ Other (Describe) |
| | _____ |
| | _____ |

5. Person(s) Suspected of Criminal Violation (If more than one, use Continuation Sheet.)

a. Name _____
first middle last

b. Address _____
street city state zip

c. Date of Birth _____ Social Security No. _____
(if known) mo/day/yr (if known)

d. Relationship to the insurance entity. Check all applicable item(s)

_____ Officer

_____ Lawyer

_____ Director
 _____ Employee
 _____ Accountant
 _____ Consultant
 _____ Third Party Administrator
 _____ Managing General Agent
 _____ Agent/Broker
 _____ Appraiser

_____ Employee Benefit Plan Service
 _____ Stockholder
 _____ Policyholder
 _____ Other (Specify)

e. Is person still affiliated with the insurance entity?

_____ yes _____ no If no, _____ Terminated _____ Resigned

FORM OMB-1105-0054

EXP. AUG.95

f. Is person affiliated with any other insurance entities?

If yes, please identify _____

6. Explanation/Description of Suspect Activity (You may use a separate sheet)

Give an account of the suspected criminal activity.

7. Witnesses

If known, list any witnesses who might have information about the suspected violation and describe their position or employment. Indicate if they have been interviewed. (Use continuation sheet if necessary.)

Name	Position	Address	Tele.	Interviewed	
				Yes	No
(1) _____	_____	_____	_____	_____	_____
(2) _____	_____	_____	_____	_____	_____

[9.] 8. Is this matter the subject of any civil law suit or regulatory action including liquidation or insolvency proceedings? If so, please describe.
[please describe.]

[10.] 9. Has a referral or complaint been made about this or a related matter or individual to a state insurance regulatory agency, law enforcement, a U.S. Attorney’s Office, State Attorney General’s Office or other prosecutor’s office? If so, please describe.

[11.] 10. Distribution Information

- a. Send one copy to the office of the Federal Bureau of Investigation (FBI) nearest to where the suspected offense took place.

FBI office to which form was sent:

city/state

- b. If the allegations are false claims or mail fraud, please send one copy to the Postal Inspection Service nearest to where the suspected offense took place.

[offense took place.]

Postal Inspection Service office to which form was sent:

city/state

- c. Send one copy to: U.S. Department of Justice, Criminal Division, Fraud Section, 10th & Pennsylvania NW, Washington, DC 20530, Attention: Karen Morrissette, Deputy Chief.

- d. In addition, if the allegations in this referral involve any of the categories as listed below, please send a copy to the corresponding agency listed below and indicate that the referral was sent.

- 1. Employee Benefit Plans (ERISA); Multiple Employer Trusts or Welfare arrangements.

Send to: Office of Labor Racketeering
U.S. Department of Labor
Room S-5012
200 Constitution Avenue
Washington, DC 20210

Referral sent Yes ____ No ____

Pension & Welfare Benefits
Administration
Enforcement Section
U.S. Department of Labor
Room N - 5702
200 Constitution Avenue
Washington, DC 20210

Referral sent Yes ____ No ____

2. Tax Violations; Bank Secrecy Act/Money Laundering

Send to: Internal Revenue Service
Criminal Investigation Division
1111 Constitution Avenue
Room 2143
Washington, DC 20224
Attn: Director of Operations
Referral sent Yes ____ No ____

[12.] 11. Person to contact for further information about referral

Name _____
Position _____
Organization _____
Phone No. _____
Date of referral _____

Public reporting for this collection of information is estimated to average one hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspects of this collection of information, including suggestions for reducing this burden to Fraud Section, Criminal Division, U.S. Department of Justice, Washington, DC 20530; and to The Office of Management and Budget, Washington, DC 20503.

Section 86.6(b)(1) is amended to read as follows:

(1) Establishment of a full time Special Investigations Unit separate from the underwriting or claims functions of the insurer, which shall be responsible for investigation of cases of suspected fraudulent activity and for implementation of the insurer’s fraud prevention and reduction activities under the Fraud Prevention Plan. In the alternative the insurer may contract with a provider of services to perform all or part of this function, but shall remain primarily responsible for the development and implementation of its Fraud Prevention Plan. The agreement under which such services are provided shall be filed with the [Insurance Frauds Bureau] Department’s Criminal Investigations Unit as part of the Fraud Prevention Plan, and must provide for specified levels of staffing devoted to the investigation of suspected fraudulent claims. In the event

that investigators employed by a provider of services will be working for more than one insurer or on cases in states other than New York, the plan must apportion the percentage of the investigator's efforts which will be devoted to working for the insurer on its New York cases. The agreement shall also require that the provider of services cooperate fully with the Department of [Insurance] of Financial Services in any examination of the implementation of the Fraud Prevention Plan, and provide any and all assistance requested by the [Insurance Frauds Bureau] Criminal Investigations Unit, any other law enforcement agency or any prosecutorial agency in the investigation and prosecution of insurance fraud and related crimes.

Section 86.6(b)(4) is amended to read as follows:

(4) A description of the relationship between the Special Investigations Unit and the claims and underwriting functions of the insurer, including procedures for detecting possible fraud, criteria for referral of a case to the Unit for evaluation, and the designation of the individuals authorized to make such a referral; and a description of the relationship between the Unit and the [Insurance Frauds Bureau] Department's Criminal Investigations Unit, other law enforcement agencies and prosecutors, including procedures for case investigation, detection of patterns of repetitive fraud involving one or more insurers, criteria for referral of a case to the [Insurance Frauds Bureau] Criminal Investigations Unit, designation of the individuals authorized to make such referrals, and a policy to avoid duplication of effort due to concurrent referrals by the Unit to more than one law enforcement agency.

Section 86.6(d) is amended to read as follows:

(d) Every insurer required to file a fraud prevention plan shall file an annual report with the [Insurance Frauds Bureau] Department's Criminal Investigations Unit no later than January 15 of each year on a form approved by the superintendent, describing the insurer's experience, performance and cost effectiveness in implementing the plan and its proposals for modifications to the plan to amend its operations, to improve performance or to remedy observed deficiencies. The report shall be reviewed and signed by an executive officer of the insurer responsible for the operations of the Special Investigations Unit.

Section 87.1(a), (b), (c) and (d) are amended as follows:

(a) The name of any proposed domestic insurance corporation, the name of any foreign or alien insurer seeking to be licensed in this State, and the proposed name of any insurer seeking to change its name shall be submitted to the Office of General Counsel, New York State [Insurance] Department of Financial Services, One Commerce Plaza, Albany, N.Y. 12257.

(b) There shall be paid to the Superintendent of [Insurance] Financial Services, at the time of submittal, a processing fee of \$25 for each proposed name submitted for approval. This fee is a nonrefundable reimbursement of the cost of the [Insurance] Department of Financial Services for such processing.

(c) In the event a proposed name is disapproved by the [Insurance] Department of Financial Services, one substitute name may be submitted for approval without an additional processing fee.

(d) In the event a proposed name is approved by the [Insurance] Department of Financial Services, it shall be reserved for the exclusive use of the prospective domestic corporation or foreign or alien insurer for a period of six months upon a payment of a fee of \$25.

Section 88.1 is amended as follows:

Section 1105 of the Insurance Law provides that when an authorized insurer proposes to cease to maintain its existing licensing status in this State, it shall submit a plan that will protect the interests of the people of this State. Such plan must be approved by the Superintendent of [Insurance] Financial Services before becoming effective. The purpose of this Part is to implement these provisions of the Insurance Law.

Section 88.2 is amended as follows:

An insurer proposing for any reason to cease to maintain its existing licensing status in this State shall, at least 45 days prior to such proposed action, submit to the Superintendent of [Insurance] Financial Services, for his approval, a plan to protect the interests of the people of this State.

Section 88.3(m) and (n) are amended as follows:

(m) A provision that the insurer will remain subject to appropriate assessments, examination by the New York State [Insurance] Department of Financial Services and shall be liable for the costs of examination under applicable statutes until notice is given that reports are no longer required.

(n) A provision that, to the extent necessary to secure the execution of the insurer's responsibilities, the payments of any claims and the satisfaction of its liabilities, the insurer will remain subject to the provisions of New York statutes and regulations affecting its operations and to the jurisdiction of the New York State [Insurance] Department of Financial Services.

Section 93.5 is amended as follows:

Each life insurer engaging in the aircraft reinsurance business shall maintain accounting records [which] that adequately reflect the operations of its aircraft reinsurance line of business in a manner similar to that of a fire or casualty insurer doing the same kind of business. Such records shall distinguish, as reasonably practical, between the reinsurance of conventional aircraft and space vehicles. In this respect Insurance [Department] Regulation No. 33 (11 NYCRR 90-91) will be applicable to the allocation of expenses to such line of business. Each life insurer engaging in such business shall report to the superintendent in such manner and at such times as the superintendent may hereafter prescribe with respect to this line of business and the funds applied thereto.

Section 94.4(b)(1)(ii)(b)(4) is amended as follows:

(4) Example: A study of your company's group claim termination rates shows that for claims terminating in the first 24 months from date of disablement its claim termination rates are 120 percent of those of the 1987 Commissioners Group Disability Income Table found in Group Long-Term Disability Valuation Tables, Transactions of Society of Actuaries 1987, Volume XXXIX, pp. 393 through 457 [1] (87CGDT) and for months 25 through 60 (years three through five) are 110 percent of the 87CGDT. A copy of such document, as adopted by the Society of Actuaries, 475 N. Martingale Road, Suite 800, Schaumburg, IL 60173-2226, in 1988 is available for public inspection at the [Insurance] Department of Financial Services offices at One Commerce Plaza, Albany, New York 12257 and at [25 Beaver] One State Street, New York, New York 10004. Your

company has an open claim as of December 31, 2002 that has a date of disablement of July 31, 2001 and an elimination period of 180 days. In order to calculate the claim reserve:

Section 94.6(d)(2) is amended as follows:

(2) In the event an insurer has a contract or a group of related similar contracts, for which future gross premiums will be restricted by contract, [Insurance] Department of Financial Services regulations, regulatory approval for rate changes, or for other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the insurer shall establish contract reserves for such shortfall in the aggregate.

The introductory paragraph to Section 94.8 is amended as follows:

The morbidity tables required by this Part are based on exposures that include contracts on premium waiver as in-force contracts. Hence, contract reserves based on these tables are not reserves on “active lives” but rather reserves on contracts “in force.” This is true for the 1964 Commissioners Disability Table Volume III Committee Recommendation and Basic Tables pp. i, iii, and 1 through 16² (64CDT) and for both the 1985 Commissioners Individual Disability Tables A found in Report of the Committee to Recommend New Disability Tables for Valuation Transactions of Society of Actuaries 1985, Volume XXXVII, pp. 449 through 466³ (85CIDA) and 1985 Commissioners Individual Disability Tables B found in APPENDIX to Report of October 18, 1984 to National Association of Insurance Commissioners (NAIC) Life, Health and Accident Standing Technical Actuarial (EX5) Task Force concerning Proposed New Minimum Valuation Standards for Loss of Time (Disability Income) Benefits NAIC Proceedings - 1985 Vol. I, pp. 486 through 540⁴ (85CIDB). Copies of such documents, as adopted by the Health Insurance Association of America, 1201 F Street, NW, Suite 500, Washington, DC 20004-1204, in 1965, the Society of Actuaries, 475 N. Martingale Road, Suite 800, Schaumburg, IL 60173-2226, in 1986, and the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662, in 1983, respectively, are available for public inspection at the [Insurance] Department of Financial Services offices at One Commerce Plaza, Albany, NY 12257 and at [25 Beaver] One State Street, New York, NY 10004. Accordingly, tabular reserves using any of these tables should value reserves on the following basis:

²1964 COMMISSIONERS DISABILITY TABLE Copyright 1965 by Health Insurance Association of America, in Washington, DC.

³TRANSACTIONS OF SOCIETY OF ACTUARIES 1985, VOLUME XXXVII Copyright 1986 by Society of Actuaries, in Schaumburg, Illinois.

⁴NAIC PROCEEDINGS - 1985 VOL. I Copyright 1985 by National Association of Insurance Commissioners, in Kansas City, Missouri.

Section 94.10(a)(1)(ii)(a)(2) is amended as follows:

(2) for contracts issued on or after January 1, 1982: The 1974 Medical Expense Tables, Table A (page 63), found in Anthony J. Houghton’s and Ronald M. Wolf’s paper Development of the 1974 Medical Expense Tables Transactions of the Society of Actuaries, Volume XXX, pp. 9 through 123⁶ shall be used. Refer to the paper, including its discussions, for methods of adjustment for benefits not directly valued in Table A. Copies of the Reserves for Individual Hospital and Surgical Expense Insurance -- 1956 Hospital Surgical Table and Development of the 1974 Medical Expense Tables as adopted by the Society of Actuaries, 475 N. Martingale Road, Suite 800, Schaumburg, IL 60173-2226, in 1957 and 1978, respectively, are available for

public inspection at the [Insurance] Department of Financial Services' offices at One Commerce Plaza, Albany, NY 12257 and at [25 Beaver] One State Street, New York, NY 10004.

⁶TRANSACTIONS OF SOCIETY OF ACTUARIES 1978, VOLUME XXX Published by Society of Actuaries in Schaumburg, Illinois; not copyrighted.

Section 94.10(a)(1)(iii)(a) is amended as follows:

(a) Contract reserves. For contracts issued on or after January 1, 1986: The 1985 NAIC Cancer Claim Cost Tables, ATTACHMENT FOUR - D, NAIC Proceedings - 1986 Vol. I, pp. 601 through 624 ⁷ shall be used. A copy of such document as adopted by the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662, in 1986 is available for public inspection at the [Insurance] Department of Financial Services' offices at One Commerce Plaza, Albany, NY 12257 and at [25 Beaver] One State Street, New York, NY 10004.

⁷NAIC PROCEEDINGS - 1986 Vol. I Copyright 1986 by National Association of Insurance Commissioners, in Kansas City, Missouri.

Section 94.10(a)(1)(iv)(a) is amended as follows:

(a) Contract reserves. For contracts issued on or after January 1, 1965: The 1959 Accidental Death Benefits Table found in Norman Brodie's and William J. November's paper A New Table for Accidental Death Benefits Transactions of Society of Actuaries 1959, Volume XI, pp. 749 through 763 ⁸ (59ADB Table) shall be used. A copy of such document as adopted by the Society of Actuaries, 475 N. Martingale Road, Suite 800, Schaumburg, IL 60173-2226, in 1959 is available for public inspection at the [Insurance] Department of Financial Services' offices at One Commerce Plaza, Albany, NY 12257 and at [25 Beaver] One State Street, New York, NY 10004.

⁸TRANSACTIONS OF SOCIETY OF ACTUARIES 1959, VOLUME XI Published by Society of Actuaries in Schaumburg, Illinois; not copyrighted.

Section 94.10(c)(1) is amended as follows:

(1) Unless paragraph (3) or (4) of this subdivision applies, the mortality basis used for all individual policies and group certificates, except long-term care insurance individual policies or group certificates issued on or after January 1, 1997, shall be the table specified in the Insurance Law or other Parts of this Title (but without use of selection factors) as the minimum standard permitted, for the valuation of whole life insurance issued on the same date as the health insurance contract. For example: the 1980 Commissioners Standard Ordinary Table found in Report of the Special Committee to Recommend New Mortality Tables for Valuation Transactions of Society of Actuaries 1981, Volume XXXIII, pp. 617 through 669 (80CSO) ⁹ could be used on an optional basis as of January 1, 1981 and therefore for this purpose the appropriate date would be January 1, 1981. A copy of such document as adopted by the Society of Actuaries, 475 N. Martingale Road, Suite 800, Schaumburg, IL 60173-2226, in 1981 is available for public inspection at the [Insurance] Department of

Financial Services' offices at One Commerce Plaza, Albany, NY 12257 and at [25 Beaver] One State Street, New York, NY 10004.

⁹TRANSACTIONS OF SOCIETY OF ACTUARIES, VOLUME XXXIII Copyright 1982 by Society of Actuaries in Schaumburg, Illinois.

Section 95.2 is amended as follows:

This Part is issued pursuant to the authority granted to the Superintendent of [Insurance] Financial Services of the State of New York under sections 107, [201,] 301, 308, 310, 1301, 1303, 1304, 4217, 4232 and 4240 of the Insurance Law and Section 202 of the Financial Services Law.

Section 95.5(a)(6) is amended as follows:

(6) Any company requesting any exception from or waiver of any of the requirements of this Part, or [which] that is required to file any statement or memorandum pursuant to section 95.9 or 95.11 of this Part, shall submit such request, statement or memorandum to the superintendent on or before the time it files its annual statement with the superintendent pursuant to Section 307 of the Insurance Law, attention of:

Life Bureau, Actuarial Valuation Unit
New York State [Insurance] Department of Financial Services
One Commerce Plaza
Albany, New York 12257

Section 95.7(b)(2) is amended as follows:

(2) The regulatory authority paragraph shall include a statement such as the following: "Said company is exempt pursuant to 11 NYCRR 95 (New York Insurance [Department] Regulation 126) from submitting a statement of actuarial opinion based on an asset adequacy analysis. This opinion, which is not based on an asset adequacy analysis, is rendered in accordance with Section 95.7 of the regulation."

Section 95.7(b)(6)(i) is amended as follows:

(i) Are computed in accordance with those presently accepted actuarial standards of practice and actuarial compliance guidelines [which] that specifically relate to the opinion required under Section 95.7 of New York Insurance [Department] Regulation 126 to the extent not inconsistent therewith and in accordance with the requirements of such regulation, and which are consistently applied;

Section 95.7(b)(7) is amended as follows:

(7) A paragraph should document the eligibility for the company to provide an opinion as provided by this section. It shall include the following:

"This opinion is provided in accordance with section 95.7 of [New York] Insurance [Department] Regulation 126. As such it does not include an opinion regarding the adequacy of reserves and related actuarial items when considered in light of the assets which support them.

Eligibility for section 95.7 is confirmed as follows based on the annual statement for the year ended December 31, [19] 20 _____ :

(iv) To my knowledge, based on such inquiry as I considered reasonable, the NAIC Examiner Team [for the] has not designated the company as a first priority company in either [19] 20 _____ or [19] 20 _____ generally based on the annual statements for [19] 20 _____ and [19] 20 _____, or a second priority company in each of such years or the company has resolved the first or second priority status to the satisfaction of the commissioner of the state of domicile.

(v) To my knowledge, based on such inquiry as I considered reasonable, there is not a specific request from the insurance regulator in any jurisdiction in which the company does business requiring an asset adequacy analysis opinion.”

Section 95.7(b)(8) is amended as follows:

(8) The concluding paragraph may state purposes for which the opinion is rendered, for example:

“This opinion is prepared for the use of company management and the New York Department of [Insurance] Financial Services for the purposes set forth in New York Insurance Law § 4217 and 11 NYCRR 95 (Insurance Regulation 126). This opinion covers business in force as of December 31, [19[]] 20 _____ and does not cover new business issued subsequent to this date.

Signature of Appointed Actuary

Address of Appointed Actuary

Telephone Number of Appointed Actuary

Date Opinion is Signed

Section 95.8(b)(6)(i) is amended as follows:

(i) Are computed in accordance with those presently accepted actuarial standards of practice [which] that specifically relate to the opinion required under Section 95.8 of New York Insurance [Department] Regulation 126 to the extent not inconsistent therewith and in accordance with the requirements of such regulation, and [which] that are consistently applied and [are] fairly stated, in accordance with sound actuarial principles;

Section 95.8(b)(vi) is amended as follows:

(vi) Make adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts.

The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, to the extent not inconsistent with [New York] Insurance [Department] Regulation 126 and conform to the requirements of such regulation.

This opinion is updated annually as required by statute. To the best of my knowledge, there have been no material changes from the applicable date of the annual statement to the date of the rendering of this opinion, which should be considered in reviewing this opinion.” Or

“The following material change(s) [which] that occurred between the date of the statement for which this opinion is applicable and the date of this opinion should be considered in reviewing this opinion: (Describe the change or changes.)” Note: Choose one of the above two paragraphs, whichever is applicable. “This opinion is prepared for the use of company management and the New York [Insurance] Department of Financial Services for the purposes set forth in New York Insurance Law § 4217, and 11 NYCRR 95 [and] (Insurance Regulation 126), as amended from time to time. This opinion covers new business issued subsequent to this date. This opinion does not cover all matters needed to assess the future capital and surplus adequacy of the company. The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion. The analysis of asset adequacy portion of this opinion should be viewed recognizing that the company’s future experience may not follow all the assumptions used in the analysis.

Signature of Appointed Actuary

Address of Appointed Actuary

Telephone Number of Appointed Actuary

Date Opinion is Signed.”

Section 95.9(c) is amended as follows:

(c) conformity to standards of practice. The memorandum shall include a statement:

“The actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board to the extent, not inconsistent with 11 NYCRR 95 ([New York] Insurance [Department] Regulation No.126) and conform to the requirements of such regulation.”

Section 95.11(d)(1) is amended as follows:

(1) “This opinion is provided in accordance with Section 95.11 of New York Insurance [Department] Regulation 126. As such it does not include an opinion regarding the adequacy of reserves and related actuarial items when considered in light of the assets [which] that support them. The company is not eligible for exemption from submission of a statement of actuarial opinion in accordance with Section 95.8 because the company is a category D company, for which no exemption is made.”;

Section 95.11(d)(3) is amended as follows:

(3) “The company is a category (A) (B) (C) company but is not eligible for exemption as noted by one or more of the following:

“The company has requested permission from the Superintendent under section 95.11 of [New York] Insurance [Department] Regulation No. 126 for exemption from an actuarial opinion required by section 95.8 and has received his approval on condition that the reserves maintained are not less than ____ percent of the statutory minimum reserves. The reserves held are approximately ____ percent of the statutory minimum reserves.

(iv) To my knowledge, based [of] on such inquiry as I considered reasonable, the NAIC Examiner Team (has) (has not) designated the company as a first priority company in either [19] 20 ___ or [19] 20 ___ generally based [of] on the annual statements for [19] 20 ___ and [19] 20 ___, or a second priority company in each of such years, or the company has resolved the first or second priority status to the satisfaction of the commissioner of the state of domicile.”

Section 95.11(e) is amended as follows:

(e) When reserves for any contracts and policies are determined in accordance with this Section where no actuarial opinion and memorandum acceptable to the Superintendent has been filed, the calculations for the reserves, and an accompanying explanation of the basis of such calculations, shall be sent to the Superintendent, attention of:

Life Bureau, Actuarial Valuation Unit
New York State [Insurance] Department of Financial Services
One Commerce Plaza
Albany, New York 12257

The explanation should include a demonstration of how the reserves comply with this section.

Section 98.3(n) is amended as follows:

(n) “Superintendent” means the Superintendent of [Insurance] Financial Services of the State of New York and any employee of the Department of [Insurance] Financial Services authorized to act on behalf of the superintendent.

Section 100.3(g) is amended as follows:

(g) “Superintendent” means the Superintendent of [Insurance] Financial Services of the State of New York and any employee of the Department of [Insurance] Financial Services authorized to act on behalf of the superintendent.

Section 101.8(a) is amended as follows:

(a) Notice to the superintendent of the termination, cancellation, or non-renewal of the provider stop loss insurance policy and, notice of any material change to the terms of the coverage, shall be in writing and shall be mailed or delivered to the superintendent at the following address:

New York State [Insurance] Department of Financial Services
Health Bureau
[25 Beaver] One State Street
New York, N.Y. 10004

Section 105.1 is amended as follows:

For the purpose of establishing uniformity in classifications of expenses of property/casualty insurers recorded in statements and reports filed with and statistics reported to the Superintendent of [Insurance] Financial Services, all such authorized insurers [which] that are subject to the provisions of article 23 of the Insurance Law shall observe the rules set forth below.

Section 105.20(b) is amended as follows:

(b) *[Insurance] Department of Financial Services licenses and fees. Include:*

- Agents’ licenses.
- Certificates of authority, compliance, deposit, etc.
- Filing fees.
- Fees and expenses of examination by insurance departments or other governmental agencies.

Exclude:

Items includible in claim adjustment services.

Section 106.1 is amended as follows:

For the purpose of establishing uniformity in classifications of expenses of property/casualty insurers recorded in statements and reports filed with and statistics reported to the Superintendent of [Insurance]

Financial Services, all such authorized insurers [which] that are subject to the provisions of article 23 of the Insurance Law shall observe the rules set forth below.

Section 107.1 is amended as follows:

For the purpose of establishing uniformity in classifications of expenses of property/casualty insurers recorded in statements and reports filed with and statistics reported to the Superintendent of [Insurance] Financial Services, all such authorized insurers [which] that are subject to the provisions of article 23 of the Insurance Law shall observe the rules set forth below.

Section 107.3(c)(2)(iii) is amended as follows:

(iii) The calculation and preparation of the aforementioned statements and data shall be subject to verification and audit by [Insurance] Department of Financial Services personnel.

Section 108.1 is amended as follows:

For the purpose of establishing uniformity in classifications of expenses of property/casualty insurers recorded in statements and reports filed with and statistics reported to the Superintendent of [Insurance] Financial Services, all such authorized insurers [which] that are subject to the provisions of article 23 of the Insurance Law shall observe the rules set forth below.

Section 109.1 is amended as follows:

For the purpose of establishing uniformity in classifications of expenses of property/casualty insurers recorded in statements and reports filed with and statistics reported to the Superintendent of [Insurance] Financial Services, all such authorized insurers [which] that are subject to the provisions of article 23 of the Insurance Law shall observe the rules set forth below.

Section 127.0(a) is amended as follows:

(a) The [Insurance] Department of Financial Services recognizes that authorized insurers routinely enter into reinsurance agreements that yield legitimate relief to ceding insurers from strain to surplus.

Section 128.0 is amended as follows:

Section 1321 of the Insurance Law authorizes the Superintendent of [Insurance] Financial Services to permit an impaired or insolvent domestic insurer or an impaired or insolvent United States branch of an alien insurer entered through this state to commute reinsurance agreements as a means of eliminating such an impairment or insolvency. This Part sets forth applicable standards that the superintendent will use in determining whether such commutations will be approved.

Section 136-1.1(a) is amended as follows:

(a) Subsection (b) of section 314 of the Insurance Law authorizes the Superintendent of [Insurance] Financial Services to promulgate certain standards with respect to the public retirement and pension systems of the State of New York or of a municipality thereof. Specifically, subsection (b) provides as follows:

“(b) Notwithstanding any other provision of law to the contrary, the superintendent shall have, in addition to any other powers conferred upon him by law, the following authority with respect to any system:

(2) to promulgate and amend from time to time, after consultation with the administrative heads of systems and after a public hearing, standards with respect to actuarial assumptions, accounting practices, administrative efficiency, discharge of fiduciary responsibilities, investment policies and financial soundness.”

Section 136-1.4(a) is amended as follows:

(a) All records, including work papers for the preparation of the annual statement filed with the [Insurance] Department of Financial Services, shall be available to the department’s examiners and shall not be destroyed unless authorized by the superintendent in writing.

Section 136-1.6(g) is amended as follows:

(g) The administrative head shall ascertain when contributions to a system are due and institute appropriate procedures to enforce prompt payment thereof. Contributions [which] that are more than three months overdue during a fiscal year shall be reported to the superintendent by a schedule appended to the annual statement filed with the [Insurance] Department of Financial Services.

Section 136-1.9 is amended as follows:

(a) Failure to implement provisions of applicable law shall be regarded as a breach of fiduciary responsibility.

(b) Any administrative head, executive or employee of a pension system subject to supervision by the Superintendent of [Insurance] Financial Services who willfully violates or knowingly participates in a violation of any standard promulgated pursuant to section 314 of the Insurance Law shall be guilty of a breach of fiduciary responsibility.

(c) In any case where, after notice and a hearing, the superintendent finds that any public pension fund has been depleted by reason of any wrongful or negligent act or omission of the administrative head, executive, employee or any other person having a fiduciary responsibility for a fund, he may transmit a copy of his findings to the Attorney General, who may proceed according to statute.

(d) The Superintendent of [Insurance] Financial Services may, after notice and hearing, transmit a finding of breach of fiduciary responsibility to the person or organization empowered to remove said trustee or other person.

Section 136-2.1(a) is amended as follows:

(a) Section 314 (b) of the Insurance Law authorizes the Superintendent of [Insurance] Financial Services to promulgate certain standards with respect to the public retirement and pension systems of the State of New York or of a municipality thereof. Specifically, subsection (b) states as follows:

“(b) Notwithstanding any other provision of law to the contrary, the superintendent shall have, in addition to any other powers conferred upon him by law, the following authority with respect to any system:

(2) to promulgate and amend from time to time, after consultation with the administrative heads of systems and after a public hearing, standards with respect to actuarial assumptions, accounting practices, administrative efficiency, discharge of fiduciary responsibilities, investment policies and financial soundness...”

Section 136-2.3(g) is amended as follows:

(g) The Comptroller shall ascertain when contributions to the retirement system are due and institute appropriate procedures to enforce prompt payment thereof. Contributions for a fiscal year [which] that are more than three months overdue shall be reported to the superintendent by a schedule appended to the annual statement filed with the [Insurance] Department of Financial Services.

Section 140.1 is amended as follows:

The purpose of this Part is to establish procedures for statistical plans for the reporting of private passenger automobile and commercial automobile statistical experience in order that this experience may be available to the New York State [Insurance] Department of Financial Services or to officially designated statistical agents of the department. This Part is applicable to insurers that write direct private passenger automobile and commercial automobile insurance business in the State of New York and to officially designated statistical agents of the department.

Section 140.2 is amended as follows:

All private passenger automobile and commercial automobile insurance statistical plans subject to this Part must be filed and approved by the Superintendent of [Insurance] Financial Services prior to implementation.

Section 145.0(a) is amended as follows:

(a) The purpose of this Part is to assure the accuracy and reliability of private passenger automobile statistical data reported to the [Insurance] Department of Financial Services by its licensed statistical agents. The statistical data provide part of the general support for insurers’ rate and classification filings and supply important information with respect to the character and composition of the market. In addition, in most

companies, the raw data utilized in a company's statistical reporting system are essentially the same data as those utilized in its ratemaking system. The accuracy and reliability of these data are of fundamental importance to the [Insurance] Department of Financial Services.

Section 145.0(b)(6) is amended as follows:

(6) Periodic Review by the [Insurance] Department of Financial Services.

Section 145.1(b) is amended as follows:

(b) all statistical agents reporting private passenger automobile statistics to the [Insurance] Department of Financial Services.

Section 145.2(a) is amended as follows:

(a) Each insurer and statistical agent shall monitor private passenger automobile statistical data in accordance with the provisions of the SDMS as required by the [Insurance] Department of Financial Services. However, the superintendent may waive or modify any SDMS requirement(s) for an individual insurer or statistical agent where the implementation of the requirement(s) would be impractical or unreasonable because of the small volume of private passenger automobile insurance premiums written by the insurer or in such other instances where the superintendent deems that such implementation would place an unreasonable burden on the insurer or statistical agent.

Section 145.2(c) is amended as follows:

(c) The superintendent shall maintain copies of the SDMS for public perusal at the offices of the [Insurance] Department of Financial Services in New York City and in Albany and at other locations within this State.

Section 151-2.1(a) is amended as follows:

(a) Section 27 of the Workers' Compensation Law requires the present value of certain awards of compensation to be deposited into the Aggregate Trust Fund on either a mandatory basis or by the discretion of the Workers' Compensation Board. The present value is discounted by a percentage rate specified by section 27. On March 13, 2007, legislation establishing comprehensive reform to New York's Workers' Compensation Law was signed into law, becoming chapter 6 of the laws of 2007. Chapter 6 amended section 27 to replace the 6% discount rate previously applicable to ATF deposits, as well as various other interest rates associated with ATF deposits, with an "industry standard rate" to be determined by the Superintendent of [Insurance] Financial Services by regulation. Section 27, as amended, applies the industry standard rate to accidents occurring on or after January 1, 2001.

Section 151-4.1 is amended as follows:

The Legislature enacted Chapter 6 of the Laws of 2007, which amended Workers' Compensation Law Section 15(8)(h), in order to close the SDF to claims for reimbursement for injuries or illnesses occurring on or after July 1, 2007, and to mandate that all claims for reimbursement be filed with the SDF prior to July 10, 2010. The legislation also amends Workers' Compensation Law section 32(i) to permit the chair of the Workers' Compensation Board to procure one or more private entities to assume the liability for, and management, administration or settlement of all or a portion of the claims in the special disability fund. Furthermore, Workers' Compensation Law section 32(i)(5) mandates that no carrier, self insured employer, or the State Insurance Fund may assume the liability for, management, administration or settlement of any claims on which it holds reserves, beyond such reserves as are permitted by regulation of the Superintendent of [Insurance] Financial Services. This purpose of this subpart is to ensure that an insurer, self-insured employer, or State Insurance Fund does not over-reserve for claims if it voluntarily assumes the liability for, or management, administration or settlement.

Section 151-6.0(b) is amended as follows:

(b) Prior to January 1, 2010, each insurer paid a percentage of the allocation based on the total direct written premiums it wrote in the preceding calendar year. However, Part QQ of Chapter 56 of the Laws of 2009 ("Part QQ") amended Workers' Compensation Law sections 15(8)(h)(4), and 151(2)(b) to change the basis upon which the board collects the portion of the allocation from each insurer. Thus, effective January 1, 2010, each insurer pays a percentage of the allocation based on the total standard premium it wrote during the preceding calendar year. Part QQ requires the [superintendent of insurance] Superintendent of Financial Services (the "superintendent") to define "standard premium," for the purposes of the assessments, and to set rules, in consultation with the board, and NYCIRB for collecting the assessment from insureds.

Section 152.1(a) and (b) are amended as follows:

(a) Section 2343(d) of the Insurance Law requires that the [Insurance] Department of Financial Services promulgate a regulation establishing a Physicians and Surgeons Professional Liability Merit Rating Plan to take effect on January 1, 1986. A merit rating plan is a system of rules for imposing rate surcharges or credits, within the existing class and territory matrix, based upon an individual's past history of claims or disciplinary actions. The plan is intended to produce a more accurate individual premium by using past claim history to predict the likelihood of future claims.

(b) At the time this regulation was first promulgated some insurers had a formal merit rating plan, while others imposed surcharges and credits on an ad hoc judgmental basis. The department believed it was in the best interests of insurers, physicians, and the public to maintain stability in the rating system by requiring all insured physicians to be experience-rated under the same set of criteria. A physician's merit rating plan was established by Section 152.3 of this Part and all insurers were required to utilize that plan, unless the superintendent approved the use of an alternative plan pursuant to Section 152.4 of this Part. The plan, which applies to all claims-made and occurrence policies, is intended to be revenue-neutral: i.e., any additional funds generated by surcharges must be offset by a rate discount factor that is applied to the base rates; over the long

term and for all insurers within the entire system. After reviewing the use of the plan established by the [Insurance] Department of Financial Services and approved alternative merit rating plans, the superintendent has determined that the use of alternative merit rating plans may be expanded and that insurers need not be restricted to the use of the plan established in this Part.

Title of Section 152.3 is amended as follows:

§ 152.3 [Insurance] Department of Financial Services Merit Rating Plan Model

Section 152.3(h) is amended as follows:

(h) Notice to insureds. When a policy has been surcharged under a merit rating plan, insurers are directed to state prominently, either on the declarations page or the premium bill, or on a notice attached to the declarations page or premium bill, the following, or its substantive equivalent:

“Your premium rates are higher than they otherwise would be because, during the measuring experience period [which] that applied to your insurance, you had the following chargeable losses or disciplinary actions under our merit rating plan. This plan has been filed with and approved by the New York State [Insurance] Department of Financial Services pursuant to Regulation No. 124 of the department. The attached description of our merit rating plan includes a list of events for which we may surcharge you, the circumstances under which surcharges may be removed and refunded, and the procedure you should follow if you wish to appeal this surcharge. We trust this will answer any questions you have concerning your surcharge. If you have any further questions, you may call us at _____.”

Section 154.1(b)(3) is amended as follows:

(3) the interaction of the previous two paragraphs with the various [Insurance] Department of Financial Services initiatives to depopulate the AIP (e.g., the territorial credit program).

Section 160.2(a) is amended as follows:

(a) Basis for rates in competitive markets. The purpose of the law is to encourage the freest and fastest response of prices to competitive and cost conditions, recognizing the special difficulties in ratemaking in the insurance industry, with the fewest regulatory restraints on competition consistent with the public interest. In constructing rates, insurers and rating organizations must in good faith consider and base rates upon the factors named in sections 2303 and 2304 of the Insurance Law. In refining and applying these factors, management shall be guided by sound judgment, accepted financial and insurance practices, the opinions of qualified technical experts within the areas of their expertise, and prevailing and anticipated conditions. The past interpretations and standards of the [Insurance] Department of Financial Services are not necessarily controlling. Ordinarily, in the construction of a rate or [of] rates, an insurer or rating organization will rely upon past loss and expense experience likely to have reliability as a predictor of the costs [which] that may be experienced on the business, which, it is anticipated, will be written at the rate or rates. In the exercise of informed and technically competent judgment, such experience may consist of an insurer’s own past experience, the past experience of other insurers, or reasonable combination of both. For the rating organization, such experience may consist of the loss and expense experience of members, or members and subscribers, or of other insurers or rating organizations, or a reasonable combination of these. Where past

expense or loss experience or both is not credible or is incomplete or where conditions affecting the validity of the experience have changed, or where it is reasonably anticipated that conditions affecting the validity of the experience are likely to change, rates may be predicated on informed judgment fairly exercised on the basis of the best available data.

Section 161.0(b) is amended as follows:

(b) Among the components of this omnibus legislation is a significant change, a flexible-rating system (“flex-rating”), pursuant to new section 2344 of the Insurance Law, amended in part by chapter 235 of the Laws of 1989, in regard to rate changes for property/casualty commercial insurance markets not subject to prior approval. Since January 1, 1970, most commercial insurance markets have been subject to a competitive rating system, which permitted insurers on a file and use basis to revise rates upward or downward without prior approval of the Superintendent of [Insurance] Financial Services. This competitive rating system relied almost exclusively upon interaction among market forces, tending to produce wide cyclical swings in commercial insurance rates.

Section 165.1(a) is amended as follows:

(a) Section 2323 of the Insurance Law directs the Superintendent of [Insurance] Financial Services, by regulation, to establish a method for determining and reporting profitability for each kind of property and liability insurance. Specifically, subsections (a) and (b) of section 2323 provide as follows:

“(a) The superintendent shall by regulation establish a method for determining profitability, from whatever source such profits are derived, and rates of return on net worth, assets and earned premiums, with respect to each kind of insurance subject to this article, based on reasonable and uniform assumptions, including assumptions as to (1) amounts of net worth attributable to such kinds of insurance, (2) assets available for investment generated by such kinds of insurance, (3) federal income taxes, and (4) average earnings on insurers’ investments.

(b) The regulation shall require insurers annually to report to the superintendent, who will make these reports available to the public, concerning such profitability and rates of return.”

Section 165.2(h) is amended as follows:

(h) Annual updating of tables I, II and III. The percentages and ratios shown in tables I, II and III will be updated annually by the [Insurance] Department of Financial Services. Thus, for 1975 profit computations, the data in tables I, II and III will be based on the experience of the five-year period 1970 through 1974.

Section 165.3(a)(2) is amended as follows:

(2) The reports are to be filed in triplicate no later than April 1 of the year following, and shall be presented on forms to be supplied by the [Insurance] Department of Financial Services.

Section 166-1.7(a) is amended as follows:

(a) Annually, the [Insurance] Department of Financial Services shall determine the total amount of excess profit dollars to be distributed, in accordance with the following procedure: A six-year excess profit shall equal the six-year average of the annual rates of return on net worth (computed in accordance with section 166-1.6 of this Subpart), minus 21.0 percent. The resulting figure, if positive, shall be divided by the average country-wide earned premium-to-net worth ratio of the six-year period, thus stating the excess profit as a percentage of premiums. This percentage shall then be multiplied by the six-year total direct earned premiums for New York motor vehicle insurance, to produce the total dollar amount to be returned to New York policyholders.

Section 166-1.7(e) and (f) are amended as follows:

(e) The [Insurance] Department of Financial Services shall determine annually the liability of each insurer for its share of any excess profit to be returned, and notify such insurer thereof.

(f) Procedures [which] that insurers shall follow in returning excess profits. (1) Each insurer's share of total excess profits to be returned, as determined by the [Insurance] Department of Financial Services shall be allocated to each of its current New York insureds who is of record as of the date of distribution, in accordance with a fair, practicable and nondiscriminatory plan for refunds or credits, which shall be established by such insurer.

Section 166-2.6(d) is amended as follows:

(d) The simpler formula is adequate for the task at hand. New York's underwriting results are derived from the New York State [Insurance] Department of Financial Services Loss and Expense Ratios, which in turn is compiled from individual-insurer annual statement and insurance expense exhibit data. The second major data source for the simpler formula is Best's Aggregates and Averages, from which industrywide all-lines investment results are derived and which is compiled from individual-insurer annual statement data. The department is satisfied that the results they give are reliable.

Section 176.2(d) is amended as follows:

(d) With the enactment of chapter 567 of the Laws of 1983, the Legislature took specific action to insert a "prudent individual" rule in the Insurance Law, rather than rely merely on other requirements of law, statutory or otherwise. By such action, the Legislature made such provision subject to the superintendent's interpretative authority under section 301(c) of the Insurance Law. The legislative history of chapter 567 demonstrates that the "prudent individual" provision was added to the Insurance Law at the insistence of the [Insurance] Department of Financial Services, and that the Legislature expected that the investment operations of life insurers would be monitored closely by the [Insurance] Department of Financial Services in order to ensure that the boards of directors are appropriately discharging their responsibilities.

Section 186.9(a) is amended as follows:

(a) No policy of credit property insurance, certificate, application, or other form pertaining to credit property insurance subject to section 2340 of the New York Insurance Law and to this Part shall be issued or

delivered in this State unless such form has been filed with the Superintendent of [Insurance] Financial Services and approved by him.

Section 187.2(a) and (b) are amended as follows:

(a) No policy of credit unemployment insurance and no certificate, application, notice of proposed group insurance, or other form pertaining to credit unemployment insurance shall be issued or delivered in this State unless such forms and the premium rates, identifiable charges, and/or rating procedures therefor have been filed with the Superintendent of [Insurance] Financial Services and approved by him.

(b) If a group policy of credit unemployment insurance has been or is delivered in another state before or after the effective date of this Part [December 27, 1988], the insurer shall be required to file the certificate of group insurance, notice of proposed group insurance, if any, to be delivered or issued for delivery in this State as specified in section 187.4(c)--(d) of this Part (together with its certification that the provisions of said group policy are consistent or shall be made consistent with the provisions of said certificate or notice of proposed group insurance) and such forms may be approved (1) if they conform to the requirements specified in said subdivisions, and (2) if the schedules of premium rates applicable to the insurance evidenced by such certificate or notice are not in excess of either the insurer's schedule of premium rates or rates produced by the rating procedures on file with and approved by the Superintendent of [Insurance] Financial Services.

Section 187.3(a)(2) is amended as follows:

(2) Under any other plan approved by the Superintendent of [Insurance] Financial Services, benefits payable after such waiting periods and upon such conditions as he shall approve.

Section 187.4(d)(7) is amended as follows:

(7) a description of the eligibility requirements for the insurance, as referred to in subdivision (b) of this section (this requirement may be provided in the credit insurance disclosure statement or equivalent form) shall be delivered to the debtor at the time such indebtedness is incurred. Such application for an individual policy or notice of proposed group insurance shall include a statement that, if the insurance is declined by the insurer or otherwise does not become effective, any premium or identifiable charge will be refunded or credited to the debtor pursuant to the provisions of section 187.7 of this Part. The copy of the application for an individual policy and the notice of proposed group insurance shall refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless set forth therein in a separate provision with an appropriate and prominent caption on the face or reverse thereof in bold face type at least equal in size to the type used for the other provisions thereof. The application for credit unemployment insurance must clearly and conspicuously disclose to the debtor: (i) that the credit unemployment insurance is not required by the creditor, and (ii) the cost of the credit unemployment insurance.

The insurer shall be responsible for establishment of procedures for delivery of the individual policy or certificate of group insurance to the debtor upon the insurance becoming effective, or within 30 days of the date upon which the indebtedness is incurred. Said application or notice of proposed group insurance shall provide that, upon acceptance by the insurer, the insurance coverage provided shall become effective as specified in section 187.6(c) of this Part, unless the insurer has theretofore demonstrated to the satisfaction of the

Superintendent of [Insurance] Financial Services that in deferring the effective date of the insurance the contract conforms to the standards of section 3201(b)(1) and (c)(7) of the Insurance Law.

Section 187.4(e)(9) is amended as follows:

(9) other reasons as approved by the Superintendent of [Insurance] Financial Services.

Section 187.4(j)(6) is amended as follows:

(6) the method of computation and manner of charging and collecting premiums or identifiable charges for each class or classes of debtors; provided, however, that paragraph (1) of this subdivision need not be set forth in the group policy if such paragraph is set forth in the trust or agency agreement and any amendments thereto. No such policy shall be issued until after the trust or agency agreement has been filed with the Superintendent of [Insurance] Financial Services and found unobjectionable by him.

Section 187.5(a)(4) is amended as follows:

(4) Except upon good cause shown and with the approval of the Superintendent of [Insurance] Financial Services, an insurer shall not issue insurance in case of loans, except those subject to section 187.12 of this Part, repayable in less than 18 monthly installments wherever a debtor shall be required to pay a premium or identifiable charge in connection with credit unemployment insurance providing indemnities of less than \$30 per month.

Section 187.5(b) and (c) are amended as follows:

(b) The term of any credit unemployment insurance shall, subject to acceptance by the insurer if required, and unless otherwise permitted pursuant to section 187.4(d) of this Part commence on the date when the debtor becomes obligated to the creditor, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness, unless otherwise expressly authorized by the Superintendent of [Insurance] Financial Services, shall commence on the effective date of the group certificate.

(c) Notwithstanding anything in the preceding subdivisions to the contrary (1) the insurance of borrowers, who incur indebtedness arising from the granting of policy loans pursuant to policy provision therefor, provided under a group policy issued to the insurance company granting the policy loan, may be continued for the duration of the indebtedness, and (2) under any plan expressly approved by the Superintendent of [Insurance] Financial Services the insurance of debtors under a group policy with respect to an agreement [which] that does not provide for repayment in installments may be continued for the duration of such indebtedness but not more than seven years from the date such indebtedness is incurred.

Section 187.7(b) is amended as follows:

(b) In the case of credit unemployment insurance, a refund of premium or identifiable charge shall be made for any portion of premium or charge covering a period beyond any one of the following:

(1) the date on which termination of insurance becomes effective; or

(2) in the case of monthly installment, the installment due date nearest the date of termination; or

(3) the date based on a procedure allowed by the Banking Law and used for determining any unearned interest on the loan; or

(4) the date based on any other procedure filed by the insurer and approved by the Superintendent of [Insurance] Financial Services.

Termination shall include termination for any reason, including death. In the case of single premiums or advance premiums or single identifiable charges pertaining to insurance reducing in equal monthly amounts, a refund shall be equal to the premium [which] that would be required for the remaining period of coverage assuming all payments were paid as scheduled, commonly known as the “Rule of Anticipation” shall be considered acceptable. An insurer may file for approval any other formula [which] that produces a reasonable result. Each insurer shall file for approval and include in the policy appropriate formulas and/or factors for refund, or reference to such formulas and/or factors as are on file with the Superintendent of [Insurance] Financial Services. No refund or credit need be made if the amount is less than \$1.

Section 187.8(e) is amended as follows:

(e) Each insurer shall file with the Superintendent of [Insurance] Financial Services its schedule of rates of commissions, and other fees or allowances to agents and brokers pertaining to the solicitation or sale of credit insurance and of fees or allowances, exclusive of amounts payable to persons who are in the regular employ of the insurer other than as agent or broker, to any individuals, firms or corporations pertaining to the service or administration of the credit insurance. Such schedules must separate compensation for solicitation of sale from compensation for services or administration of the credit insurance. Such schedules must separate compensation for solicitation of sale from compensation for services or administration of the credit insurance. An insurer may revise such schedules from time to time, and shall file such revised schedules with the Superintendent of [Insurance] Financial Services. No insurer shall pay an amount of compensation other than as filed with the Superintendent of [Insurance] Financial Services. Fees for service or administration may be payable to a policyholder or creditor to the extent the policyholder or creditor performs such service on behalf of the insurer. Each insurer shall file or refile its schedules of compensation no later than the dates on which new premium rates are to be filed in accordance with section 187.6(e)(4) of this Part, for classes of policies to which such compensation schedules apply and shall be implemented on the same dates as such new filed premium rates are implemented.

Section 187.9(d)(1) is amended as follows:

(1) refunded to those debtors insured on the date of payment to the policyholder, if distributed by the policyholder, or on the date of mailing if distributed directly by the insurer. The insurer shall be responsible for determining the allocation of the refund to debtors. In the event the policyholder distributes the refunds, the insurer shall be responsible to ascertain that in fact such refunds are made and in accordance with the allocation procedure set by the insurer. In the event the policyholder fails to make such refunds, then the insurer shall notify the Superintendent of [Insurance] Financial Services and thereafter shall make the refunds directly or shall use one of the other acceptable procedures below;

Section 187.11(a) is amended as follows:

(a) Each insurer writing credit unemployment insurance shall maintain statistics for credit unemployment insurance, subject to call by the Superintendent of [Insurance] Financial Services from time to time, on a policy-year basis, or calendar-year basis at the option of the insurer, for group policies and on a calendar-year basis for individual policies, separately for direct business and reinsurance assumed:

Section 187.12(a)(7)(ii) is amended as follows:

(iii) by any other method as the Superintendent of [Insurance] Financial Services may approve.

Section 187.12(a)(9)(iv) is amended as follows:

(iv) any other plan approved by the Superintendent of [Insurance] Financial Services.

Section 201.1 is amended as follows:

The trustees of every employee welfare fund shall give written notice to the [Insurance] Department of Financial Services of:

Section 201.2 is amended as follows:

Every notice required to be given by this Part shall be addressed to the New York State [Insurance] Department of Financial Services, Life Bureau, [25 Beaver] One State Street, New York, NY 10004, and shall include a copy or copies of all pertinent agreements and other writings or documents referred to therein.

Section 202.2(b) is amended as follows:

(b) In lieu of the above 10-year level scale, an insurer may use a scale [which] that provides for a higher rate in the first policy year than in the next nine policy years, provided such rates are mathematically equivalent to the above scale and are approved in advance in writing by the Superintendent of [Insurance] Financial Services. Compensation after the tenth policy year, if payable, shall be only for the servicing of such insurance. Overriding commissions payable to a general agent shall not exceed 25 percent of commissions payable to the agent.

Section 202.5 is amended as follows:

The insurer shall file with the Superintendent of [Insurance] Financial Services the scales of commissions and schedules of fees and allowances payable under this Part, including any compensation for servicing such business in the eleventh and subsequent years.

Section 215.5(c) is amended as follows:

(c) An advertisement of a policy shall contain in a prominent place and style the appropriate statement for the coverage provided, as determined by the definitions in 11 NYCRR 52.5-52.11 (Insurance Regulation No. 62), as follows:

(1) This policy meets the minimum standards for basic hospital insurance as defined by the New York State [Insurance] Department of Financial Services. It does NOT provide basic medical or major medical insurance. The expected benefit ratio for this policy is _____ percent. This ratio is the portion of future premiums [which] that the company expects to return as benefits, when averaged over all people with this policy.

(2) This policy meets the minimum standards for basic medical insurance as defined by the New York State [Insurance] Department of Financial Services. It does NOT provide basic hospital or major medical insurance. The expected benefit ratio for this policy is _____ percent. This ratio is the portion of future premiums [which] that the company expects to return as benefits, when averaged over all people with this policy.

(3) This policy meets the minimum standards for major medical insurance as defined by the New York State [Insurance] Department of Financial Services. It does NOT provide basic hospital or basic medical insurance. The expected benefit ratio for this policy is _____ percent. This ratio is the portion of future premiums [which] that the company expects to return as benefits, when averaged over all people with this policy.

(4) This policy provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State [Insurance] Department of Financial Services. The expected benefit ratio for this policy is _____ percent. This ratio is the portion of future premiums [which] that the company expects to return as benefits, when averaged over all people with this policy.

(5) This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State [Insurance] Department of Financial Services. The expected benefit ratio for this policy is _____ percent. This ratio is the portion of future premiums [which] that the company expects to return as benefits, when averaged over all people with this policy.

(6) This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State [Insurance] Department of Financial Services. The expected benefit ratio for this policy is _____ percent. This ratio is the portion of future premiums [which] that the company expects to return as benefits, when averaged over all people with this policy. **IMPORTANT NOTICE--THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.**

(7) This policy provides DENTAL insurance only. The expected benefit ratio for this policy is _____ percent. This ratio is the portion of future premiums [which] that the company expects to return as benefits, when averaged over all people with this policy.

(8) This policy meets the minimum standards for MEDICARE SUPPLEMENT INSURANCE as defined by the New York State [Insurance] Department of Financial Services. The expected benefit ratio for this policy is _____ percent. This ratio is the portion of future premiums [which] that the company expects to return as benefits, when averaged over all people with this policy. **IMPORTANT NOTICE--A CONSUMER'S**

GUIDE TO HEALTH INSURANCE FOR PEOPLE ELIGIBLE FOR MEDICARE MAY BE OBTAINED FROM YOUR LOCAL SOCIAL SECURITY OFFICE OR FROM THIS INSURER.

Such statements may be made to conform to the actual insurance provided where such insurance complies with more than one of the definitions contained in such sections 52.5 through 52.11. The requirements for disclosure of the expected benefit ratios of policies as provided in this section shall not apply to group policies as defined in sections 221 and 253(6) of the Insurance Law.

Section 216.4(c) and (d) are amended as follows:

(c) Every insurer shall establish an internal department specifically designated to investigate and resolve complaints filed with the [Insurance] Department of Financial Services and to take action necessitated as a result of its complaint investigation findings. Such internal department is to operate in a staff capacity to the entire company with authority to question and change the position taken in individual instances or company practices generally. Responsibility for such department is to be vested in a corporate officer who is also to be entrusted with the duty of executing the [Insurance Department's] Department of Financial Services' directives. If the [Insurance] Department of Financial Services requests the appearance of an insurer representative to discuss a pending matter, the individual whom the company sends shall be authorized to make any determination warranted after all the facts are elicited at such conference. Each insurer must furnish the superintendent with the name and title of the corporate officer responsible for its internal consumer services department.

(d) Every insurer, upon receipt of any inquiry from the [Insurance] Department of Financial Services respecting a claim, shall, within 10 business days, furnish the department with the available information requested respecting the claim.

Section 216.5(b) is amended as follows:

(b) Where there is a reasonable basis, supported by specific information available for review by [Insurance] Department of Financial Services examiners, that the claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this Part. The provisions of this Part are suspended for the period required to investigate the alleged fraudulent aspects of the claim. The insurer must submit the report required by Part 86 [(Insurance Frauds Bureau)] (Criminal Investigations Unit) of this Title when an insurer determines that a loss is suspect.

Section 216.8(h)(1) is amended as follows:

(h) Reporting requirement and cooperation with law enforcement agencies. (1) The central organization and each insurer authorized to issue automobile comprehensive insurance policies covering losses incurred to private passenger vehicles shall, upon the request of any appropriate law enforcement agency or insurance organization engaged in automobile loss prevention, release information in its possession resulting from an investigation conducted by it pertaining to such comprehensive loss, including information as such agency or organization deems related to its investigation. Should the central organization or the insurer be of the opinion that the loss was caused by any criminal or fraudulent act of any person or organization, or that an improper action occurred in the disposition of an automobile subject to the provisions of this section, the central organization or the insurer shall notify the [Insurance Department's] Department of Financial Services' [Frauds

Bureau] Criminal Investigations Unit and any other appropriate law enforcement agency or insurance organization engaged in automobile loss prevention of that opinion, and shall notify the [Insurance] Department of Financial Services or Department of Motor Vehicles of any improper action of their respective licensees or registrants.

Section 216.8(h)(3)(1) – (3) are amended as follows:

(1) amend the policy by adding thereto the endorsement as set out in this subdivision, which is hereby deemed approved upon filing with the [Insurance] Department of Financial Services;

(2) submit for [Insurance] Department of Financial Services' approval the insurer's own substantially similar endorsement; or

(3) submit for [Insurance] Department of Financial Services' approval the insurer's basic policy form incorporating the substance of the endorsement set out in this subdivision.

Section 216.9(b) is amended as follows:

(b) Nothing in subdivision (a) of this section shall create, or be construed to create, a cause of action for any person or entity, other than the [Insurance] Department of Financial Services, against the insurer or its representative based upon a failure to serve such notice, or the defective service of such notice. Nothing in subdivision (a) of this section shall establish, or be construed to establish, a defense for any party to any cause of action based upon a failure by the insurer or its representative to serve such notice, or the defective service of such notice.

Section 216.10(g) is amended as follows:

(g) In the processing of third-party property damage claims, the time limitations of subdivisions (e) and (f) of this section shall not be applicable if there is objective evidence available for review by [Insurance] Department of Financial Services examiners that anyone involved in the accident who may assert a bodily injury liability claim against the insured has sustained a serious injury as defined in section 5102 of the Insurance Law. Such claim shall be settled or denied in accordance with the provisions of section 216.6 of this Part.

Section 216.11 is amended as follows:

To verify compliance with this Part and related statutes, [Insurance] Department of Financial Services examiners will investigate the market performance of insurers. To enable department personnel to reconstruct an insurer's activities, all insurers subject to the provisions of this Part must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurer shall be dated by the insurer. Claim files must be so maintained that all events relating to a claim can be reconstructed by the [Insurance] Department of Financial Services examiners. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimants.

The form in Section 216.12 entitled "Insurer Letterhead Notice of Rights Under Your Physical Damage

Insurance Policy” is amended as follows:

INSURER LETTERHEAD

**NOTICE OF RIGHTS UNDER YOUR
PHYSICAL DAMAGE INSURANCE POLICY**

INSURED _____
CLAIM # _____
POLICY # _____
DATE OF ACCIDENT _____

Dear Insured:

We have been unable, after negotiating in good faith, to reach an agreed price with you, your Designated Representative and/or your repairer _____, the repairer of your choice. Pursuant
(name of repair shop)

to Insurance Regulation 64 of the New York State [Insurance] Department of Financial Services, we are supplying you with the following information and optional waiver.

Our offer of \$ _____ plus your deductible of \$ _____ and \$ _____ of betterment or previous damage deduction is sufficient to repair your vehicle to its pre-accident condition at a repair shop located reasonably convenient to you. We are able to provide you with the identity of the repair shop that will repair your vehicle at our estimate, but under the Insurance Law we may not recommend a repairer unless you expressly request such information. Unless you have already asked us to recommend a repair shop, you must sign the attached *Section 2610 of the Insurance Law Disclosure Statement* in order to enable us to make such recommendation.

If your vehicle is repaired at a repair shop recommended by us, the repair shop must issue a written guarantee that any work performed in repairing your vehicle meets generally accepted standards for safe and proper repairs. If our recommended repairer does not honor its written guarantee, we will restore your vehicle to its pre-accident condition within a reasonable time at no additional cost to you.

Your policy covers you for reasonable expenses that you incur in order to protect your motor vehicle from further damage after a loss. Contact us immediately for information as to what extent such expenses are covered.

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Section 218.7(c) and (d) are amended as follows:

(c) The information required to be maintained by subdivisions (a) and (b) of this section shall be kept current and made available to the [Insurance] Department of Financial Services upon its request.

(d) Reports for each full calendar year containing the information required to be maintained in subdivisions (a) and (b) of this section, shall be filed with the [Insurance] Department of Financial Services annually on May 1 after the close of the preceding calendar year. Such reports shall be made in a format to be prescribed by the superintendent and every such report shall be public record.

The title of section 220.5 is amended as follows:

Section 220.5. Reports to the Superintendent of [Insurance] Financial Services

Section 240.1(c) is amended as follows:

(c) Every such entity shall designate in writing to the Superintendent of [Insurance] Financial Services the officer who shall be primarily responsible for maintaining the security and confidentiality of information received in effectuation of the mandate of sections 4311 and 320 of the Insurance Law.

Section 241.1(a)

(a) A current list, detailed by subject matter, of all records in the possession of the department shall be available for public inspection and copying in the department's Bureau of Public Affairs and Research, One Commerce Plaza, Albany, NY 12257 [, (518) 474-6615,] or [25 Beaver] One State Street, New York, NY 10004[, (212) 480-2283]. The list shall specify whether records are available at the department's Albany or New York City office or both offices.

Section 241.5(a) is amended as follows:

(a) The fiscal officer of the department, designated pursuant to the Freedom of Information Law, is the director of the [bureau of taxes and accounts] Revenue & Billing Unit, in the department's Albany office[, (518) 474-8567].

Section 241.6(c)(1) is amended as follows:

(1) Within seven business days of receipt of written notice denying the request, the person may file a written appeal from the determination of the department with the Superintendent of [Insurance] Financial Services or his designated representative.

Section 242.4(a) is amended as follows:

(a) Records shall be made available at the main office of the agency, which is located at:

[Insurance] Department of Financial Services
One Commerce Plaza
Albany, NY 12257

Section 242.2(b) is amended as follows:

(b) The address and telephone number of the privacy compliance officer is:

Office of General Counsel
[Insurance] Department of Financial Services
One Commerce Plaza
Albany, NY 12257
(518) [473-0785] 473-3795

and

Office of General Counsel
[Insurance]Department of Financial Services
[25 Beaver] One State Street
New York, NY 10004
(212) [480-5259] 480-5287

Section 242.8(c) is amended as follows:

(c) Any such denial may be appealed to:

[Deputy Superintendent and] Deputy General Counsel
New York State [Insurance] Department of Financial Services
[25 Beaver] One State Street
New York, NY 10004

Section 261.0(e) is amended as follows:

(e) In the past, the [Department] department has received many inquiries requesting clarification as to what kinds of prepaid legal services arrangements constitute the doing of an insurance business, thus requiring licensing as an insurer. As guidance on this issue, it is the [Department's] department's interpretation that legal services arrangements pursuant to which legal services are provided for a prepaid fee do not constitute the doing of an insurance business within the meaning of section 1101 of the Insurance Law so long as the services are not dependent upon the happening of a fortuitous event (as such term is defined in section 1101 (a)(2) of the Insurance Law) in which the recipient of the services has, or is expected to have at the time of such happening, a material interest [which] that will be adversely affected by the happening of such event. For example, an arrangement that, for a prepaid fee, provides that the recipient of services is entitled to a will upon request would not constitute the doing of an insurance business, so long as the arrangement is not conditioned upon the happening of a fortuitous event. Therefore, a prepaid legal services arrangement providing such limited services and being offered by an unlicensed entity would not be subject to the jurisdiction of the [Insurance] Department of Financial Services.

Section 261.0(h) is amended as follows:

(h) Pursuant to Chapter 65 of the laws of 1998, an authorized insurer may provide noninsurance benefits pursuant to a prepaid legal services plan, so long as the insurer is licensed to write legal services insurance. An insurer, however, is not required to offer legal services insurance as part of the plan. Such prepaid legal services plans are subject to the jurisdiction of the [Insurance] Department of Financial Services because they

are offered by licensed entities and regardless of whether or not they include legal services insurance as part of the plan.

Section 301.8(d) is amended as follows:

(d) Service of legal documents or process upon a purchasing group may be made at the offices of the department during normal and ordinary business hours, pursuant to the power of attorney executed by the purchasing group, by serving the superintendent, any deputy superintendent, or any salaried employee of the [Insurance] Department of Financial Services whom the superintendent designates for such purposes, with two copies thereof and a fee of \$ 20.

Section 360.9(c)(9) is amended as follows:

(9) To register with the superintendent the names of association groups pursuant to paragraph (8) of this subdivision, a letter must be sent to the Health [and Life Policy] Bureau of the [Insurance] Department of Financial Services on or before April 1, 1993. For each association group to be registered the letter shall list:

Section 380.2(c) is amended as follows:

(c) Each individual or entity who has filed an application for a license as a viatical settlement company or a viatical settlement broker prior to or within 90 days after the date the Superintendent of [Insurance] Financial Services has promulgated regulations regarding licensing or by July 30, 1994, whichever date is earlier, may act as a viatical settlement company or viatical settlement broker without a license issued pursuant to this section until the superintendent has made a final determination on the application for such license filed by such individual or entity.

Section 380.3(g) and (h) are amended as follows:

(g) Any company submitting an application for a license shall secure approval for its name in accordance with section 1201 of the Insurance Law and Part 87 of this Title. Any broker applying to use other than the applicant's personal name shall apply to the Licensing Bureau of the [Insurance] Department of Financial Services for prior approval of that name. Approval of names by the Secretary of State does not comply with the requirements of the Insurance Law.

(h) Each broker or company shall immediately notify the Licensing Bureau [or Corporate Affairs Bureau, respectively,] of the [Insurance] Department of Financial Services in Albany[,], of any change in the address of the licensee and of any change in the members, officers or employees who are designated to act on behalf of the licensee. Any such licensee, except one [which] that is publicly traded, shall make immediate notification of any change in its stockholders.

Section 380.4(a) and (b) are amended as follows:

(a) Each licensed viatical settlement company or viatical settlement broker must file with the [Insurance] Department of Financial Services on or before March 1st of each year an annual statement (in duplicate) in a form designated as the "Viatical Settlement Company Blank" or "Viatical Settlement Broker Blank".

(b) The [Insurance] Department of Financial Services shall furnish each company and broker with one copy of the designated statement blank. The contents of the statement blank designated shall be subject to amendment or change from year to year.

Section 380.5(h) is amended as follows:

(h) All charges, including necessary traveling and other actual expenses, as audited and paid by the comptroller to the persons making the examination or appraisal, shall be presented to the company or broker in the form of a copy of the itemized bill as certified and approved by the superintendent or by any deputy superintendent or authorized employee of the [Insurance] Department of Financial Services.

Section 390.9(a) is amended as follows:

(a) The notice to the superintendent of termination of the service contract reimbursement insurance policy required by section 7909 of the Insurance Law shall be in writing and shall be mailed or delivered to the superintendent at the following address:

New York State [Insurance] Department of Financial Services
Licensing Bureau--Registration Unit
One Commerce Plaza
Albany, NY 12257

Section 390.10(d)(1) is amended as follows:

(d) *Audited financial statements.* (1) On or before June 30th of each year, or 180 days after the end of the service contract provider's fiscal year, whichever is later, the provider shall file its audited financial statements for the prior calendar year with the superintendent. The statements shall include an opinion of an independent certified public accountant. The statements and opinion shall be mailed or delivered to the superintendent at the following address:

New York State [Insurance] Department of Financial Services
Property Bureau--Service Contract Providers
[25 Beaver] One State Street
New York, NY 10004-2319

Section 390.11(a)(1) is amended as follows:

(a) *Audited financial statements.* (1) On or before June 30th of each year or 180 days after the end of the service contract provider's fiscal year, whichever is later, the service contract provider shall file its audited financial statements for the prior calendar year with the superintendent. If the audited financial statements of the provider's parent or indirect parent are used to meet the provider's financial responsibility requirement, then the parent or indirect parent shall file the statements and the 180 days shall be counted from the parent's or indirect parent's fiscal year. The statements shall include an opinion of an independent certified public accountant. The statement and opinion shall be mailed or delivered to the superintendent at the following address:

New York State [Insurance] Department of Financial Services
Property Bureau--Service Contract Providers
[25 Beaver] One State Street
New York, NY 10004-2359

Section 390.11(b) is amended as follows:

(b) If the statements of the service contract provider's parent or indirect parent are used to meet the provider's financial responsibility requirement, then the parent or indirect parent shall guarantee the provider's obligations relating to the service contracts sold by the provider in this state. The provider shall mail or deliver the guarantee to the superintendent with the registration application at the following address:

New York State [Insurance] Department of Financial Services
Licensing Bureau--Registration Unit
One Commerce Plaza
Albany, NY 12257

Section 400.1(a) is amended as follows:

(a) This Part implements section 11 of the Tax Law, as added by section 144 of chapter 389 of the Laws of 1997, which provides for the establishment of certified capital companies and confers authority on the [Insurance] Department of Financial Services [(the department)] (the "department") to certify and regulate such companies. Section 11 of the Tax Law creates a tax credit incentive mechanism to increase investment of financial resources of insurers into the State's venture capital markets. Section 1511(k) of the Tax Law, as added by section 143 of chapter 389, describes the operation of the tax credit. In section 142 of Chapter 389, the Legislature made a finding that, in order to promote the growth of the State economy, a need exists to further encourage the investment of private financial resources into the State's venture capital markets, emphasizing viable smaller business enterprises [which] that traditionally have had difficulty in attracting institutional venture capital. In addition, the legislation and this Part implement the legislative goal of promoting the formation and expansion of new and existing businesses, thereby creating jobs and resulting in growth in the State's economy.

Section 400.3(a) is amended as follows:

(a) A partnership, corporation, trust or limited liability company organized on a for-profit basis that is located, headquartered and licensed or registered to conduct business in New York and has as its primary business activity the investment of cash in qualified businesses may make application to the Superintendent of [Insurance] Financial Services to be designated as a certified capital company. The application form, including filing instructions, may be obtained upon request by contacting:

New York State [Insurance] Department of Financial Services
[Taxes and Accounts Bureau] Revenue & Billing Unit
One Commerce Plaza
Albany, NY 12257
(518) 474-8567

Section 410.6(c) is amended as follows:

(c) Following certification:

(1) if an external appeal agent acquires ownership or control of, or becomes owned or controlled by, or acquires and begins to exercise common control with any entity described in paragraphs (1) through (3) of subdivision (a) of this section, the external appeal agent shall notify the Departments of [Insurance] Financial Services and Health in writing within five business days of such acquisition or exercise of control. Such notice shall be sufficient basis for the revocation of certification without a hearing; and

(2) the sworn statement required by subdivision (b) of this section shall be amended and resubmitted to the Departments of [Insurance] Financial Services and Health within five business days of the addition or deletion of any material affiliation as described in subparagraphs (i) through (v) of paragraph (2) of subdivision (b) of this section.

Section 420.0(d) and (e) are amended as follows:

(d) This Part provides that a licensee subject to the supervision of the Superintendent of [Insurance] Financial Services who, in the conduct of the business of insurance in this State, violates the provisions of this Part shall be deemed to have engaged in an unfair method of competition or an unfair or deceptive act and practice in the conduct of the business of insurance in this State. Such act shall be deemed to be a trade practice constituting a determined violation, as defined in section 2402(c) of the Insurance Law, in violation of section 2403 of such law.

(e) In addition to the foregoing, the Superintendent of [Insurance] Financial Services possesses the authority pursuant to section[s 201 and] 301 of the Insurance Law and section 202 of the Financial Services Law to promulgate a regulation to delineate the responsibility of [an Insurance] a Department of Financial Services licensee regarding the privacy of consumer and customer financial and health information [which] that the licensee receives. Such authority is an exercise of the superintendent's power to promulgate regulations to effectuate any power given to the superintendent under the Insurance Law, including the provisions regarding transactions within a holding company system affecting controlled insurers (section 1505); relations and transactions between parent and subsidiary companies for life and property/casualty insurers (sections 1608 and 1712); minimum standards in the form, content, and sale of accident and health insurance policies and contracts (section 3217); and, as noted above, unfair methods of competition or unfair or deceptive acts and practices (Article 24).

Section 420.1(a) is amended as follows:

(a) *Purpose.* This Part governs the treatment of nonpublic personal information about individuals (defined in this Part as consumers or customers) in this State by all licensees of the [Insurance] Department of Financial Services. This Part:

Section 430.4(a)(2) is amended as follows:

(2) two members appointed by the Superintendent of [Insurance] Financial Services, at least one of which is a representative of eligible health care providers; and

Section 430.4(b)(4)(i) is amended as follows:

(i) any member of the Plan may be authorized by the Board, with the approval of the Superintendent of [Insurance] Financial Services, to service the assignments of other members of the Plan that desire to be relieved of their responsibility to service their assignments; or

Section 430.6(b) is amended as follows:

(a) The superintendent shall make an examination into the affairs of the Plan as often as the superintendent deems necessary pursuant to Section 309 of the Insurance Law. The examination shall be conducted and the report filed in the manner prescribed in Article 3 of the Insurance Law.

(b) The expenses of the examination shall be paid by the Plan in the manner prescribed by [Section 313 of the Insurance Law] Section 206(f) of the Financial Services Law.

Appendices 10A, 10B, 10C, 11, 13-A, 15, 16, and 22 of this Title are repealed. New Appendices 10A, 10B, 10C, 11, 16, and 22 of this Title are added.

Forms NF 1A, NF 1B, NF 4 and NF 5 of Appendix 13 of this Title are repealed and new Forms NF 1A, NF 1B, NF 4 and NF 5 of Appendix 13 of this Title are added.



NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

I, Benjamin M. Lawsky, Superintendent of Financial Services, do hereby certify that the foregoing is the consolidated action amending multiple Parts of 3 NYCRR and 11 NYCRR; repealing forms NF 1A, NF 1B, NF 4 and NF 5 of appendix 13; repealing appendices 10A, 10B, 10C, 11, 13-A, 15, 16 and 22; adding new forms NF 1A, NF 1B, NF 4 and NF 5 of appendix 13; and adding new appendices 10A, 10B, 10C, 11, 16 and 22, signed by me on May 16, 2013 pursuant to the authority granted by Sections 202 and 302 of the Financial Services Law and Section 301 of the Insurance Law, to take effect on August 1, 2013.

Pursuant to the provisions of the State Administrative Procedure Act, prior notice of the proposed amendment was published in the State Register on February 20, 2013. No other publication or prior notice is required by statute.

Benjamin M. Lawsky
Superintendent of Financial Services

Date: May 16, 2013