

NEW YORK STATE DEPARTMENT OF
FINANCIAL SERVICES

Individual Long Term Care Insurance Checklist
for SERFF Filings (3/30/2021)
(Tax-Qualified and Non-Partnership)

Instructions for SERFF Checklist:

- A. For **ALL** filings, the “General Requirements for All Filings” and the “Review of Product Outline” sections **MUST** be completed.
- B. For a **FORM** filing, completion of additional sections may be required as follows depending on the type of form being submitted:
- Policy – Also complete the “Policy Form” section.
 - Rider or endorsement – Also complete all items in the “Policy Form” section relevant to the form being submitted.
 - Application – Also complete the “Application Forms” section.
- C. For filing of **RATES** for **NEW** products, complete the “New Products – Rate Requirements” section in addition to completion of the applicable form sections identified above. For filing of **RATE** changes to **EXISTING** products (increases, decreases, or change in rate calculation rules or procedures), complete the “Existing Products-Rate Requirements” section. For filing of any OTHER changes to RATE or underwriting manuals (e.g., changes in commissions or underwriting), complete the “Existing Products-Rate Requirements” section.
- D. For each item, enter in the last column the form number(s), page number(s) and paragraph(s) where the requirement is met in the filing or insert a bookmark connecting to the appropriate location in the filing. All items with shaded boxes must be answered.
- E. Do not make any changes or revisions to this checklist.
- F. **Checklist Updates:** Any items on the checklist that have been updated since the last posting are shaded.
- G. **Instructions for Citations:** All citations to Department of Financial Services regulations link to the Department of State’s website and an unofficial copy of the NYCRR. Please select title 11 for Insurance regulations. Most of the pertinent form and rate regulations are located in Chapter III Policy and Certificate Provisions, Subchapter A Life, Accident and Health Insurance. All citations to New York Laws (Insurance Laws or other New York laws) link to the public LRS website. To locate the Insurance Laws, please select the link labeled “ISC”.
- H. **Combination Life Insurance & Long Term Care:** Please see page 17.

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 (TAX-QUALIFIED AND NON-PARTNERSHIP)

LINE OF BUSINESS: Individual Long Term Care

LINE(S) OF INSURANCE

CODES

CODE: LTC03I

Qualified/Non-Partnership

LTC03I.001

IF CHECKLIST IS NOT APPLICABLE, PLEASE EXPLAIN:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
GENERAL REQUIREMENTS FOR ALL FILINGS			Form/Page/Para Reference
FILING SUBMISSION			
Filing Type	11NYCRR52.2(k) 11NYCRR52.19 11NYCRR52.70 §1117	This filing is: (select only one) <input type="checkbox"/> Individual. It meets the following requirements: NO premium discount. (An individual filing may have a premium discount for factors such as spousal/domestic partner, preferred risk, etc. However, if the filing has a premium discount for group or quasi-group marketing methods, it must meet the requirements of Franchise or Request for Waiver of the Franchise Rules filings below. See Section XIX of the product outline for full explanation.) Individual minimum loss ratio. Available to any individual in the general public. No exclusivity as insurer. No sponsorship. No mass marketing. Regular individual sales methods on a one-to-one basis. No employer or association contributions toward premium. Insurer may have a premium remittance agreement with an employer or association that is willing to participate in a payroll deduction arrangement, but the agreement	

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		<p>is irrelevant to how the coverage is being sold.</p> <p><input type="checkbox"/> Franchise by meeting the following requirements: Franchise definition per §52.2(k). General rules for franchise insurance per §52.70(a). All form content requirements for franchise per §52.19. Class and participation requirements per §§52.70(b) and (c). Policy states whether rates will increase when franchise relationship ends. If the rates will increase, the increase in rate upon cessation of the arrangement is disclosed prominently on the cover page of policy or the policy schedule AND in the application.</p> <p><input type="checkbox"/> Request for Department's waiver of the franchise rules under §1117 by meeting the following requirements: (See product outline for full explanation) Maximum premium discount is 10% for issue ages 65 and over and 15% for issue ages 64 and under. <i>Note: Actuarial justification must be provided.</i> Expected loss ratio at least 70% Form is NOT available to general public No exclusivity -- Insurer cannot require that any employer or association endorsement is exclusive to the insurer Involvement by employer or association is passive (e.g., No employer or association sponsorship and employer or association contributes no more than 50% toward insured's premium) If an employer or association contributes toward premium payment, its contribution level does not exceed 50% of the premium due from any individual insured. No mass marketing Discount remains if insured's relationship with employer or association ends for any reason</p>	
Form Requirements	11NYCRR52.12 11NYCRR52.13 11NYCRR52.31 §3102(c)(1)(G)	<p>Each form in the filing must meet the following requirements:</p> <p>a. Nursing home and home care benefits paid under this policy will never be less than the statutory and §52.12 regulatory minimums as of the date of this checklist. <i>Note: If the insurer wishes to reduce long term care benefits on a limited basis to a level below the minimums required by §52.12, attach an explanation indicating that this limited exception is possible because coverage for a nursing home and home care policy is still attained under §52.13. The limited §52.13 benefit must include prominent disclosure of the lesser benefit level by using the §52.13 label.</i></p> <p>b. This form contains no strikeouts. §52.31(b)</p> <p>c. All blank spaces are filled in with hypothetical data. §52.31(f)</p> <p>d. If the form contains more than 3 pages or more than 3,000 words, the form contains a table of contents. §3102(c)(1)(G)</p> <p>e. If the form contains variable material, the form contains minimal variable material and a full explanation of the nature and scope of the variable material is attached in the filing. §52.31(k)</p> <p>f. If the form is available to spouses or dependents, select only one:</p> <p><input type="checkbox"/> The spouse/dependent receives their own individually issued policy, OR</p> <p><input type="checkbox"/> The spouse/dependent is covered under the one policy issued to the primary insured.</p>	

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Discrimination	§2606 , §2607 , & §2608	Unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, and marital status are prohibited.	
CONSUMER INFORMATION			
Required Disclosure Form	11NYCRR52.54 11NYCRR52.65 11NYCRR52.25(c)(6)	The filing includes the required disclosure form that: <ul style="list-style-type: none"> a. Will accompany or be incorporated in the policy when delivered OR delivered to the applicant at the time application is made and receipt is acknowledged. b. Contains language that conforms to §52.65 of Regulation 62. c. Contains a graphic comparison of the benefit levels of a policy that increases benefits over the policy with a policy that does not increase benefits. The graphic comparison shows benefit levels over at least a 20-year period. d. Contains any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer also discloses the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases. An insurer may use a reasonable hypothetical or a graphic demonstration. 	
APPLICATION FORMS			Form/Page/Para Reference
Agent Statement	11NYCRR52.29(b)	If an agent (i.e., not direct response) takes the application, the application must contain the statement signed by the agent.	
Authorization	11NYCRR420.18(b)	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.	
Caution Statement	11NYCRR52.25(d)(3)(i)	The language must be set out conspicuously and in close conjunction with the applicant's signature block on the application.	
Conversion	11NYCRR52.51(g)	If this application is an application for conversion coverage, the application does NOT contain questions as to the health of the person(s) entitled to conversion.	
Extra-Hazardous Activities	11NYCRR52.2(i) 11NYCRR52.16(e)(2)	If the application contains questions as to whether the applicant has engaged in or contemplates participation in a number of specified activities, the insurer will adhere to the following Regulation 62 guidelines regarding "extra-hazardous" activities: The Department permits an insurer to exercise a number of options depending upon whether or not the activity engaged in by the applicant is an extra-hazardous activity as defined by the Department in §§52.2(i) and 52.16(e)(2). If the activity engaged in by the applicant is <u>within</u> the Department's definition of an extra-hazardous activity, the insurer may elect one of four options:	

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		<p>a. The insurer may issue a standard risk policy;</p> <p>b. The insurer may decline to issue any policy at all;</p> <p>c. The insurer may place a waiver on the policy declining coverage for disabilities arising out of such activities; or</p> <p>d. The insurer may charge additional premiums for providing coverage for such activities. If the activity engaged in is <u>not within</u> the definition of an extra-hazardous activity, the Department permits the insurer to issue a standard risk policy or decline to issue any policy at all.</p>	
Fraternal Benefit Society	§4501(a)	If the insurer is a fraternal benefit society, the application asks if the applicant is a member and, if the applicant is not a member, the application requires the person to apply for membership.	
Fraud Warning Statement	§403(d)	All applications must contain the prescribed fraud warning statement.	
Health Questions	11NYCRR52.51(b)	Any question of past or present health of any person that refers to a specific disease or general health must be asked “to the best of the applicant’s knowledge and belief”. <i>Note: Does not apply to questions about factual information such as doctor visits or hospital confinements</i>	
Insurance with Other Insurers	11NYCRR52.51(h) §3216(d)(2)(D) §3216(d)(2)(E)	If the application is used with a policy subject to §3216(d)(2)(D) or §3216(d)(2)(E), “Insurance with Other Insurers”, the application contains a question requiring information with respect to other insurance.	
Investigative Consumer Report	§380-c of the General Business Law	If an Investigative Consumer Report will be prepared or procured, a notice complying with §380-c of the General Business Law is included in the application OR in a separate form.	
Medical Information Exchange Center	§321	If a Medical Information Exchange Center (such as a Medical Information Bureau) will be used, the insurer complies with §321 of the Insurance Law.	
Multiple Applications for One Policy	§4224(b)	If more than one application is used to apply for a policy, attach a full explanation of the objective criteria used to determine who completes each application. <i>Note: Objective criteria are necessary to avoid unfair discrimination.</i>	
Multiple Levels of Underwriting	§4224(b)	If more than one level of medical and financial underwriting (e.g., full underwriting, simplified underwriting, or guaranteed issue) is used for a policy, attach a full explanation of: <p>a. The various levels of underwriting.</p> <p>b. The objective criteria used to determine the use of each level of underwriting.</p>	
Other Insurance in This Insurer	11NYCRR52.51(i) §3216(d)(2)(C)	If the application is used with a policy that includes the optional standard provision under §3216(d)(2)(C), “Other Insurance in This Insurer”, the application contains a statement describing the provision in the policy OR, if provided at the time of application by separate notice, the notice is included in this filing.	
Pre-Existing Conditions	11NYCRR52.51(j) 11NYCRR52.54	If the application is used with a policy that contains a “pre-existing conditions” provision, a statement describing the policy provision is included in the application OR the statement is included in the disclosure statement required by §52.54 of Regulation 62 that is delivered at the time of application.	
Prohibited Questions and Provisions	11NYCRR52.51 §3204	The application does NOT contain: <p>a. Questions as to the applicant’s race.</p> <p>b. A provision that changes the terms of the policy to which it is attached.</p> <p>c. A statement that the applicant has not withheld any information or concealed any facts.</p>	

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		<ul style="list-style-type: none"> d. An agreement that an untrue or false answer material to the risk will render the contract void. e. An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and insured in the application, except to conform to §3204. f. A question or seek previous HIV test results. <i>Note: Information regarding the diagnosis or treatment of AIDS or ARC may be sought and used. Also, the insurer has the right to conduct its own medical tests as part of the underwriting process.</i> 	
Replacement Questions	11NYCRR52.29(a)	<p>The application must:</p> <ul style="list-style-type: none"> a. Require a list of all existing accident and health insurance policies. <i>Note: Since accident and health insurance policies include, but are not limited to, long term care insurance, nursing home insurance only, home care insurance only and nursing home and home care insurance policies, all must be included in the question.</i> b. Contain a question that asks whether this policy is intended to replace an accident and health policy presently in force. c. Require identification of those policies being replaced. 	
Telephone or In-Person Interview	§3204 Article III, NY Technology Law	<p>If a telephone or in-person interview will be used with this application, the interview is conducted in the following manner:</p> <ul style="list-style-type: none"> a. Any questions raised during the interview are limited to those questions appearing on an application approved by the Department (i.e., questions over the phone would be no different than those being asked in the application). b. The applicant must be provided with a written copy and will have an opportunity to review and make corrections to those statements that were attributed to him/her in the interview. c. Any information obtained in the interview that will be used in the underwriting process will be reduced to writing, signed by the applicant and <u>attached</u> to the policy in compliance with §3204. d. If an electronic signature is used, it must comply with the Electronic Signatures and Records Act (Article III of the New York Technology Law). e. If a telephonic application is being used, please provide a description of the procedure for taking a telephonic application. Any scripts used in the telephone interview must be filed for reference. 	
Third Party Notification	§7702B(g)(2)(A)(i)(VI) of the Internal Revenue Code	The application must provide the opportunity for an applicant to designate a third party to be notified in the event of lapsation.	
CONDITIONAL RECEIPT/INTERIM INSURANCE AGREEMENT FORM			
Advance Premium	11NYCRR52.53	If premium will be taken at the time of application, the filing should include a conditional receipt <u>OR</u> interim insurance agreement that complies with §52.53 of Regulation 62. (e.g., cannot use a hybrid receipt or agreement which is less favorable than §52.53 requirements) See product outline for brief summary of requirements.	

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Reinstatement	§3216(d)(1)(D)	If the conditional receipt is used for reinstatement, the effective date of the reinstated policy complies with §3216(d)(1)(D) of the Insurance Law. <i>Note: If premium is taken with the application and a conditional receipt is issued, coverage becomes effective on the 45th day after the date of the conditional receipt unless the insured was previously notified of approval or disapproval in writing.</i>	
POLICY FORM PROVISIONS	§1117, §3102, §3105, §3201, §3204, §3216 & 11 NYCRR Part 52 (Reg. 62) & §§213, 4980C, and 7702B of the Internal Revenue Code (incorporating portions of the NAIC Model Act as of January 1993),		Form/Page/Para Reference
COVER PAGE			
Caution Statement	11NYCRR52.25(d)(3)(ii)	The policy conspicuously contains the caution statement required by §52.25(d)(3)(ii) (e.g., cover page).	
Change in Premium		The form states that a change in premiums on a class basis is subject to the approval of the New York State Department of Financial Services.	
Changes in Federal or State Laws or Regulations		The form states that if changes in federal or state laws or regulations affect the tax-qualification status of the policy, the insurer will offer such changes to the insured for acceptance or rejection. Rejection of such changes when offered may cause the policy to lose its tax-qualified status.	
Free Look		The form contains a “free look” provision that is for a period of 30 days.	
Licensee		The licensed New York insurer’s name and full address appears prominently on the front or back cover.	
Label	11NYCRR52.12	Policy is labeled as “Long Term Care Insurance” within the definition of §52.12.	
Medicare Notice	11NYCRR52.17(a)(33)(i) 11NYCRR52.54	If the policy is sold to persons eligible for Medicare (due to age or disability), a notice complying with §52.17(a)(33)(i) is included either on the cover page of the policy OR the first page of the disclosure statement required by §52.54.	
Participating Policy	§3216(c)(1)	If the policy is <u>participating</u> , such is stated on the cover page OR schedule page.	
Reduction of Benefits or Benefit Period	11NYCRR52.17(a)(3)	If benefits are reduced due to attainment of an age limit or a benefit period reduction, such reduction is referenced on the cover OR schedule page of the policy. <i>Note: If the insurer wishes to provide benefits at a level below the minimums for long term care, minimum coverage for a nursing home and home care policy may be used with</i>	

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		<i>prominent disclosure that the insured would only be receiving nursing home and home care insurance.</i>	
Renewability	11NYCRR52.17(a)(1) 11NYCRR52.17(a)(2) 11NYCRR52.17(a)(6) 11NYCRR52.17(a)(7) 11NYCRR52.25(b)(1) §7702B(b)(1)(C) of the Internal Revenue Code	The form meets the following requirements: a. The cover indicates that the policy is guaranteed renewable. §52.17(a)(1) , §52.25(b)(1) and §7702B(b)(1)(C) of the Internal Revenue Code. b. The cover contains the renewability provision OR briefly describes and references the policy renewability provision pursuant to §52.17(a)(2) . c. The renewability provision states that the insurer has no unilateral right to make any change while the insurance is in force except that premiums may be revised on a class basis. §52.17(a)(6) . d. The form complies with §52.17(a)(7) .	
Signature of Company Officer		The signature of company officer(s) appears prominently on the form (such as on the cover).	
Tax-qualification (Federal)	§4980C(d) of the Internal Revenue Code	The form includes a statement required by HIPAA that the policy is intended to be tax-qualified under §4980C(d) of the Internal Revenue Code.	
DEFINITIONS			
Benefit Period	§3201(c)(3) §3217(b) 11NYCRR52.1(c) 11NYCRR52.1(d) 11NYCRR52.17(a)(3) 11NYCRR52.12	The definitions of “benefit periods”, “maximum benefit periods” or similar provisions that set a period for payment of benefits comply with §§3201(c)(3), 3217(b), 52.1(c), 52.1(d), 52.17(a)(3) and 52.12.	
Consumer Price Index	§3201(b)(1) , §3201(c)(3) , §3204(a)(1) , §3217(b) , 11NYCRR52.1(c) 11NYCRR52.1(d) 11NYCRR52.12	The definitions of consumer price indexes and consumer price index factors comply with §§3201(b)(1), 3201(c)(3), 3204(a)(1), 3217(b), 52.1(c), 52.1(d) and 52.12	
Elimination Period	§3201(c)(3) , §3217(b) , 11NYCRR52.1(c) 11NYCRR52.1(d) 11NYCRR52.12	The definitions of “Elimination Period”, “Waiting Period”, and similar terms comply with §§3201(c)(3), 3217(b), 52.1(c), 52.1(d) and 52.12.	
Hospital	11NYCRR52.2(m)	The definition of “Hospital” complies with §52.2(m).	
Mental Disorders	§3201(c)(3) , §3217(b) , §4224(b)(2) 11NYCRR52.1(c) 11NYCRR52.1(d) 11NYCRR52.12 11NYCRR52.25(b)(2)(ii)	The definition of “Mental Disorders” or a similar term complies with §§3201(c)(3), 3217(b), 4224(b)(2), 52.1(c), 52.1(d), 52.12, and 52.25(b)(2)(ii).	
Physician	§3201(c)(3) , §3217(b) , 11NYCRR52.1(c) 11NYCRR52.1(d) 11NYCRR52.12	The definition of “Physician” or any substitute term includes any legally qualified practitioner of the healing arts acting within the scope of his/her New York State license as appropriate to a tax-qualified policy. (i.e., chiropractor, licensed social worker, etc.) <i>Note: Form should not unduly limit the insured’s access to benefits.</i>	

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LONG TERM CARE – MINIMUM BENEFIT STANDARDS			
Minimum Benefit Coverage	11NYCRR52.12	<p>Minimum long term care coverage (Select only one):</p> <p><input type="checkbox"/> Option I Nursing home coverage: At least \$100 per day per covered person in metropolitan area counties as defined in §52.2(s) (\$70 per day in all other counties) Home care coverage: At least 50% of daily indemnity amount provided for Nursing Home coverage</p> <p><input type="checkbox"/> Option II Nursing home and home care coverage at least 60% of reasonable charges</p> <p><input type="checkbox"/> Option III Nursing home coverage: Contracting provider: At least 75% of the negotiated rate Non-contracting provider: At least 50% of the reasonable charge or \$55 per day, whichever is less. Home care coverage: Contracting provider: At least 75% of the negotiated rate Non-contracting provider: At least 50% of the reasonable charge or \$30 per day, whichever is less.</p>	
Minimum Period of Coverage	11NYCRR52.12	Minimum 24 months coverage per covered person	
Statement of Minimum Benefits to be Paid	11NYCRR52.12	The Nursing Home benefit includes language that the benefit paid will never be less than the minimum required under §52.12. The Home Care benefit includes language that the benefit paid will never be less than the minimum required under §52.12.	
Additional Benefits	11NYCRR52.12	<p>If the form provides benefits in addition to the §52.12 required nursing home and home care benefits, the form:</p> <ol style="list-style-type: none"> a. Identifies those additional benefits, b. Indicates how the use of unrequired benefits can reduce coverage limits beneath the required regulatory minimum levels for the required §52.12 benefits, and c. Advises the insured that if he/she desires minimum regulatory levels for the required benefits, then he/she should manage the use of his/her benefits accordingly. 	
Benefits Below Minimums for Long Term Care	11NYCRR52.12 11NYCRR52.13	If the §52.12 form contains any additional benefits that meet only §52.13 requirements, those additional benefits are identified as §52.13 benefits (e.g., international benefits).	
LONG TERM CARE REQUIREMENTS			
Elimination Period		<p>Form contains an Elimination Period of 180 days or less. <i>Note: If the insurer proposes an elimination period greater than 180 days, <u>attach</u> a full explanation.</i></p>	
Inflation Protection	11NYCRR52.25(c)(3)	Form <u>offers</u> an inflation protection provision that complies with §52.25(c)(3) of Regulation 62 and pertinent HIPAA and related federal requirements.	

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Non-forfeiture Benefit	11NYCRR52.25(c)(7)	Form <u>offers</u> a non-forfeiture benefit that complies with §52.25(c)(7) of Regulation 62 and pertinent HIPAA and related federal requirements.	
Return of Premium upon Death	11NYCRR52.16(b) §3228	If the form contains a return of premium on death permitted by §52.16(b), the return of premium: a. Is NOT offered as a non-forfeiture benefit. b. Complies with §3228 of the Insurance Law.	
Period of Care	11NYCRR52.25(c)(9)	If the form contains a “period of care” provision, the period of care is separated by at least 30 days of nonpayment of benefits to be considered two separate periods of care.	
Extension of Benefits	11NYCRR52.25(b)(3)	a. The form contains an Extension of Benefits provision that complies with §52.25(b)(3) of Regulation 62. <i>Note: The extension is provided for “total disability” as well as eligibility for benefits.</i> b. The term “total disability”, as used in the Extension of Benefits provision, is defined in conformance with the federal benefit triggers.	
Attained Age Rates	11NYCRR52.17(a)(29)	If the rates are based upon attained age, the forms contain the applicable schedule of rates.	
Arbitration	§3216(d)(1)(K)	The form does NOT provide for mandatory arbitration.	
Military Suspension	§3216(c)(13) §3216(c)(14) 11NYCRR52.17(a)(9) Circular Letter No. 7 (2003)	Suspension provision for insureds called to active duty in the armed forces complies with §§3216(c)(13) and (14) and §52.17(a)(9). <i>Note: When read together, an insured is entitled to the right to resumption upon termination of military service of no longer than <u>five</u> years.</i>	
“Shared” Coverage	11NYCRR52.12	If the form provides that one spouse (or a domestic partner meeting Department requirements), after depleting their policy benefits, can use the benefits of a “well” spouse, the “well” spouse’s benefits are NOT reduced to less than the minimum coverage requirements for long term care. <i>Note: If the insurer wishes to reduce the benefits to a level below the minimums for long term care, minimum coverage for a nursing home and home care policy under §52.13 may be used with prominent disclosure that the insured would only be receiving nursing home and home care insurance.</i>	
International Coverage	11NYCRR52.12 11NYCRR52.13	If the form provides international coverage, the benefits meet or exceed the minimum requirements of long term care. <i>Note: If the insurer wishes to provide benefits at a level below the minimums for long term care, minimum coverage for a nursing home and home care policy may be used with prominent disclosure that the insured would only be receiving nursing home and home care insurance.</i>	
Assignment	§3201(c)(3) , §3216(d)(1)(L) , §3217(b) 11NYCRR52.12	If the form contains an assignment provision, it complies with §§3201(c)(3), 3216(d)(1)(L), 3217(b), and 52.12.	
Update Benefits Without Evidence of Good Health		If the form contains a provision to <u>update benefits without evidence of good health</u> (e.g., issuance of a future guaranteed option increase benefit), the provision includes the insurer’s guarantee of its issue and participation limits in effect at issuance of a future guaranteed option increase benefit with no adverse change in those limits.	

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Rider or Endorsement	11NYCRR52.17(a)(14) 11NYCRR52.17(a)(5) 11NYCRR52.17(a)(6) 11NYCRR52.17(a)(12) 11NYCRR52.16(e)(2)	<p>If this filing contains a rider or endorsement, the following requirements must be met:</p> <ol style="list-style-type: none"> a. If the rider or endorsement provides a benefit for which a specific premium is charged, the premium is shown on the application, rider or elsewhere in the policy. §52.17(a)(14) b. If the rider or endorsement will be issued with an existing “guaranteed renewable” policy, such rider will be made available at the option of the insured. §52.17(a)(5) or §52.17(a)(6) c. If the rider or endorsement reduces or eliminates coverage after policy issuance, it provides for signed acceptance by the insured. §52.17(a)(12) <i>Note: For waivers issued as a condition of insurance, renewal or reinstatement, see §52.16(e)(2).</i> 	
Dependent Coverage	11NYCRR52.25(b)(4) 11NYCRR52.17(a)(10) Circular Letter No. 27 (2008)	<p>If dependents are covered under this form:</p> <ol style="list-style-type: none"> a. The form contains a conversion provision for dependents that complies with §52.25(b)(4) of Regulation 62. <i>Note: In New York State, a spouse’s right to conversion arises upon divorce or annulment.</i> b. The form includes a provision that, if a dependent is added to an inforce policy, a new contestable period for the dependent runs from the later dependent issuance date (not a new contestable period for the primary insured previously issued coverage). c. If spouses are covered under this form, then it must include the recognition of marriages between same-sex partners legally performed in other jurisdictions. 	
Domestic Partner Coverage	OGC Opinion 01-11-23	<p>The policy may extend coverage to domestic partners, but is not required. If coverage is extended to domestic partners, then proof of the domestic partnership and financial interdependence must be submitted to the insurer.</p> <p>Such proof may be in the form of: registration as a domestic partnership, where such registry exists, or for partners residing where registration does not exist, by an alternative affidavit of domestic partnership.</p> <p>The affidavit must be notarized and require at least the following:</p> <ul style="list-style-type: none"> • The partners are both eighteen years of age or older and are mentally competent to consent to contract. • The partners are not related by blood in a manner that would bar marriage under laws of the State of New York • The partners have been living together on a continuous basis prior to the date of the application; and • Neither individual has been registered as a member of another domestic partnership within the last six months. • The partners are financially interdependent. 	
Fraternal Benefit Society	§4504(g)	<p>If the insurer is a Fraternal Benefit Society, the policy includes a provision that complies with §4504(g) regarding a member’s portion of any reserve deficiency.</p>	
MANDATORY STANDARD PROVISIONS		<p><i>Note: These provisions MUST be included in each policy. The provision must be no less favorable to the insured than the statutory provision.</i></p>	
Change of Beneficiary	§3216(d)(1)(L)	<p>When applicable, this provision must be included but must be no less favorable to the insured than the statutory provision.</p>	

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Claim Forms	§3216(d)(1)(F)	This provision must be included and must be no less favorable to the insured than the statutory provision.	
Entire Contract	§3216(d)(1)(A) §3204	This provision must be included and must be no less favorable to the insured than the statutory provision of §3216(d)(1)(A). This provision must also comply with §3204. There is no incorporation by reference.	
Grace Period	§3216(d)(1)(C)	This provision must be included and must be no less favorable to the insured than the statutory provision.	
Legal Actions	§3216(d)(1)(K)	This provision must be included and must be no less favorable to the insured than the statutory provision.	
Notice of Claim	§3216(d)(1)(E)	This provision must be included and must be no less favorable to the insured than the statutory provision.	
Payment of Claims	§3216(d)(1)(I)	This provision must be included and must be no less favorable to the insured than the statutory provision.	
Physical Examinations and Autopsy	§3216(d)(1)(J)	This provision must be included and must be no less favorable to the insured than the statutory provision.	
Proofs of Loss	§3216(d)(1)(G)	This provision must be included and must be no less favorable to the insured than the statutory provision.	
Reinstatement	§3216(d)(1)(D)	This provision must be included and must be no less favorable to the insured than the statutory provision. <i>Note: If premium is taken with the application and a conditional receipt is issued, coverage becomes effective on the 45th day after the date of the conditional receipt unless the insured was previously notified of approval or disapproval in writing.</i>	
Time Limit on Certain Defenses	§4980C(c)(1)(B)(vi)	As a tax-qualified form, the “Time Limit on Certain Defenses” provision is the three-tiered incontestability provision required by HIPAA.	
Time of Payment of Claims	§3216(d)(1)(H)	This provision must be included and must be no less favorable to the insured than the statutory provision.	
OPTIONAL STANDARD PROVISIONS		<i>These provisions MAY be included at the insurer’s option.</i>	
Benefit Offsets	§3216(d)(2)(C) §3216(d)(2)(D) §3216(d)(2)(E) 11NYCRR52.23(e)(3)(i)	If the insurer wishes to offset the benefits, select from the following provisions: a. An “Other Insurance in This Insurer” provision that complies with §3216(d)(2)(C). b. An “Insurance with Other Insurers” provision that complies with §3216(d)(2)(D) or (E). <i>Note: Coordination of benefits is not allowed in an individual policy under §52.23(e)(3)(i). Insurers have the ability to financially underwrite for other coverage before issuance and have the above provisions for excess insurance situations after issuance.</i>	
Cancellation	§3216(d)(2)(H)	If this provision is included, it must comply with the standard provision language of the statutory provision and may NOT be less favorable in any respect to the insured.	
Conformity with State Statutes	§3216(d)(2)(I)	If this provision is included, it must comply with the standard provision language of the statutory provision and may NOT be less favorable in any respect to the insured.	

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Illegal Occupation	§3216(d)(2)(J)	If this provision is included, it must comply with the standard provision language of the statutory provision and may NOT be less favorable in any respect to the insured.	
Intoxicants and Narcotics	§3216(d)(2)(K)	If this provision is included, it must comply with the standard provision language of the	
Misstatement Of Age	§3216(d)(2)(B)	If this provision is included, it must comply with the standard provision language of the statutory provision and may NOT be less favorable in any respect to the insured.	
Unpaid Premium	§3216(d)(2)(G)	If this provision is included, it must comply with the standard provision language of the statutory provision and may NOT be less favorable in any respect to the insured.	
PERMISSIBLE EXCLUSIONS & LIMITATIONS			
Alcoholism and Drug Addiction	11NYCRR52.25(b)(2)(iii) , §3216(d)(2)(K)	If an insurer chooses to place an exclusion or limitation on coverage for treatment arising out alcoholism or drug addiction it must comply with §52.25 (b)(2)(iii) of Regulation 62 and §3216 (d)(2)(K) as pertinent.	
Cause of Illness, Treatment, or Medical Condition	11NYCRR52.25(b)(2)(iv)	If an insurer chooses to place an exclusion or limitation on coverage for illness, treatment, or medical condition arising out of the following situations, it must comply with §52.25(b)(2)(iv) of Regulation 62: a. war or act of war (whether declared or undeclared); b. participation in a felony, riot or insurrection; c. service in the armed forces or units auxiliary thereto; d. suicide, attempted suicide, or intentionally self-inflicted injury; or e. aviation (this exclusion applies only to nonfare paying passengers).	
Family Provider	11NYCRR52.25(b)(2)(v)	If an insurer chooses to place an exclusion or limitation on services provided by a member of the covered person's immediate family, it must comply with §52.25(b)(2)(v) of Regulation 62.	
Government Facility	11NYCRR52.25(b)(2)(v)	If an insurer chooses to place an exclusion or limitation on treatment provided in a government facility (unless otherwise required by law), it must comply with §52.25(b)(2)(v) of Regulation 62.	
Mandatory No-Fault	11NYCRR52.25(b)(2)(v)	If an insurer chooses to place an exclusion or limitation on services for which benefits are <u>provided</u> by any <u>mandatory</u> motor vehicle no-fault law, it must comply with §52.25(b)(2)(v) of Regulation 62. Note: The term "provided" is permitted, not "payable" or "reimbursable".	
Medicare or Other Governmental Program	11NYCRR52.25(b)(2)(v)	If an insurer chooses to place an exclusion or limitation on services for which benefits are <u>provided</u> by Medicare or other governmental program (except Medicaid), it must comply with §52.25(b)(2)(v) of Regulation 62. Note: The term "provided" is permitted, not "payable" or "reimbursable".	
Mental or Nervous Disorders	11NYCRR52.25(b)(2)(ii)	If an insurer chooses to place an exclusion or limitation on coverage for mental or emotional disorders, it must comply with §52.25(b)(2)(ii) of Regulation 62, which does not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or demonstrable organic brain disease.	
Outside U.S. and Possessions	11NYCRR52.25(b)(2)(vi)	If an insurer chooses to place an exclusion or limitation on coverage while the insured is outside the United States <u>and its possessions</u> , it must comply with §52.25(b)(2)(v) of Regulation 62.	

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Pre-Existing Conditions	11NYCRR52.25(b)(2)(i)	If an insurer chooses to place a preexisting condition limitation in the coverage, it must comply with §52.25(b)(2)(i) of Regulation 62. For the purposes of a long term care insurance policy, the only permissible preexisting condition limitation is one which excludes coverage, for no more than 6 months after the effective date of coverage for a condition for which medical advice was given or treatment was recommended by, or received from, a licensed health care provider within 6 months before the effective date of coverage.	
Services for Which No Charge is Normally Made	11NYCRR52.25(b)(2)(v)	If an insurer chooses to place an exclusion or limitation on services for which no charge is normally made in the absence of insurance, it must comply with §52.25(b)(2)(v) of Regulation 62.	
Workers' Compensation	11NYCRR52.25(b)(2)(v)	If an insurer chooses to place an exclusion or limitation on services for which benefits are <u>provided</u> by any state or Federal workers' compensation, employer's liability or occupational disease law, it must comply with §52.25(b)(2)(v) of Regulation 62. Note: The term "provided" is permitted, not "payable" or "reimbursable".	
PROHIBITED EXCLUSIONS AND LIMITATIONS	11NYCRR52.25(C)(1)	A long term care insurance policy may NOT limit or exclude benefits: <ol style="list-style-type: none"> a. By requiring that the covered person have a prior hospitalization or a prior specified level of care in order for another level of care in a nursing home or home care benefits to be covered. b. By requiring that the covered person first or simultaneously receive nursing and/or therapeutic services in a home or community setting before home care services are covered. c. By limiting eligible services to services provided by registered nurses or licensed practical nurses. d. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his/her license or certification. e. By requiring that the covered person have an acute condition before services covered under this policy are covered. <i>Note: Long term care policy designs that predicate benefits on "medically necessary" services or similar wording are viewed as a requirement of having an acute condition.</i> f. By limiting benefits to services provided by Medicare-certified agencies or providers. 	
RATE-RELATED INFORMATION			
Level Premium	11NYCRR52.40(b)(1)	The rates in the filing are level premium.	
Sex Basis for Rates		This form is rated on the following basis: (select only one) <ul style="list-style-type: none"> <input type="checkbox"/> Unisex basis, OR <input type="checkbox"/> Sex-distinct basis and will NOT be issued in any employer/employee situation subject to the Norris decision and/or Title VII of the Civil Rights Act of 1964. 	
Rate Guarantee	§4224(b)	If the form contains a rate guarantee, the guarantee is for a period of three years or less.	
SCHEDULE OF BENEFITS			

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Benefit Selections	11NYCRR52.31 (f) §3204 (a)(1)	The schedule page sets forth: a. elimination period choices, maximum benefit period choices, monthly benefit amounts and similar choices made by the insured. b. optional choices of insured regarding certain benefits and/or riders selected by the insured.	
Effective Date and Renewal Dates	11NYCRR52.31 (f) §3216 (c)(2)	The schedule page includes spaces for effective date of insurance, renewal dates and renewal terms.	
Hypothetical Data	11NYCRR52.31(f)	The schedule page is completed with hypothetical data.	
Name of Insured	11NYCRR52.31 (f) §3216 (c)(3)	The schedule page includes space for the insured’s name.	
Premium Summary	11NYCRR52.31 (f) §3216 (c)(1)	The schedule page contains premium summary amounts and provisions dealing with insured participation status in surplus or dividends.	
TAX-QUALIFICATION PROVISIONS			
Activities of Daily Living	§7702B(c)(2)(B) of the Internal Revenue Code	The determination that an individual is chronically ill includes at least 5 of only the following ADLs: eating, toileting, transferring, bathing, dressing and continence.	
Benefit Payment Method	§7702B(b) of the Internal Revenue Code	The form identifies benefits of the following nature within the meaning of HIPAA for favorable federal and New York State income tax treatment: <input type="checkbox"/> indemnity, or <input type="checkbox"/> expense incurred	
Benefit Triggers		The policy clearly explains the triggers for benefits payable which meet all requirements of HIPAA and related federal regulations and guidance.	
Covered Services	§7702B(b)(1)(A) of the Internal Revenue Code	Covered services conform to the definition of “Qualified long term care services”.	
Definitions-Federal	§7702B(c) of the Internal Revenue Code	*To qualify for favorable federal and New York State income tax treatment, policy meets or exceed HIPAA definitions of: “Qualified long term care services”, as defined by HIPAA and related federal regulations and guidelines, means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services and maintenance or personal care services which (A) are required by a “chronically ill individual” and (B) are provided pursuant to a plan of care prescribed by a “licensed health care practitioner”. “Chronically Ill Individual” means any individual who has been certified by a “licensed health care practitioner” as: <ul style="list-style-type: none"> • being unable to perform without “substantial assistance” from another individual at least 2 “activities of daily living” for a period of at least 90 days due to a loss of functional capacity (the ADL trigger), • having a level of disability similar to the level of disability described in the ADL 	

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		<p>trigger as determined under regulations prescribed by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services (the Similar Level trigger), OR</p> <ul style="list-style-type: none"> requiring “substantial supervision” to protect such individual from threats to health and safety due to “severe cognitive impairment” (the Cognitive Impairment trigger). <p>“Licensed health care practitioner” (e.g., such practitioner as listed in HIPAA or other individual acting within the scope of his/her New York State license as appropriate to a tax-qualified policy).</p> <p><i>* If form does not meet the express HIPAA definitions and all federal requirements for tax-qualified status, company must attach an explanation of its interpretation of HIPAA and federal requirements to make a tax-qualified submission.</i></p>	
Definitions-“Safe Harbor”	Internal Revenue Service Notice 97-31 (May 6, 1997)	The form adheres to “safe harbor” definitions as set forth in HIPAA, federal regulations and IRS interim guidance of 1997 for favorable federal and New York State income tax treatment. If not, attach an explanation of how the policy is tax-qualified. <i>Note: “Safe harbor” definitions relate to the terms “substantial assistance”, “hands-on assistance”, “standby assistance”, “severe cognitive impairment”, and “substantial supervision” for determination of a chronically ill individual.</i>	
Federal Tax Qualification	§7702B of the Internal Revenue Code	The policy complies with §7702B of the Internal Revenue Code.	
Grandfathered Policies	§7702B of the Internal Revenue Code	If this filing contains a change to be issued to existing business where a policy was issued prior to January 1, 1997, attach an explanation addressing the effect of this change on the grandfathered tax-qualified status of the policy in regard to the forfeiture of the grandfathered tax-qualified status of the policy issued prior to January 1, 1997. (e.g., material changes to business issued prior to 1/1/97 within the meaning of federal regulations and guidelines resulting in grandfathered tax-qualified status forfeiture)	
Licensed Health Care Practitioner	§7702B(c)(4) of the Internal Revenue Code	Licensed health care practitioner certifies at least once in a 12-month period that person is a chronically ill individual.	
Medicare Offset	§7702B(b)(1)(B) of the Internal Revenue Code	Forms do NOT pay or reimburse expenses incurred for services or items to extent expenses are reimbursed under Title XVIII of the Social Security Act (Medicare) or would be so reimbursed except for the application of a deductible or coinsurance amount.	
New York State Tax-qualification	§1117(g)(1)	The filing requests approval pursuant to §1117(g)(1) so it is eligible for New York State favorable income tax treatment.	
Plan of Care	§7702B(c)(1)(B) of the Internal Revenue Code	Qualified long term care services must be provided pursuant to a plan of care.	
Prohibition	§7702B(b)(1)(D) of the Internal Revenue Code	Forms do NOT provide for cash surrender value or other money that can be paid, assigned or pledged as collateral for a loan or borrowed (except to reduce future premiums or increase future benefits or as otherwise specifically allowed by HIPAA)	
Reinstatement Extension	§7702B(g)(2)(A)(i)(VI) of the Internal Revenue Code	Form includes extended reinstatement provision from HIPAA in the event of lapsation due to cognitive impairment or loss of functional capacity. <i>Note: This is in addition to the reinstatement provision mandated by §3216(d)(1)(D) of the Insurance Law.</i>	

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Reminders		<ul style="list-style-type: none"> • The company may only offer discounts that are submitted and acknowledged by the Health Bureau’s Rating Section as justifiable discounts before being placed on file by the Rating Section. • The insurer is obligated under §2611 of the Insurance Law and §2782 of the Public Health Law regarding written informed consent, authorization and disclosure of confidential information when the insurer uses an HIV antibody test in underwriting. Circular Letter 3 (1989) and Circular Letter 5 (1997) are relevant. • The insurer may make insertions to the application only for administrative purposes as long as the insertions are clearly not ascribed to the applicant. No other insertions or alterations of a written application will be made by anyone other than the applicant without his written consent pursuant to §3204. • The insurer is reminded that, pursuant to §52.25(d)(1), post-claims underwriting is prohibited whether or not information has been obtained regarding the applicant’s health condition prior to issuance of the policy. • The application asks about medications taken by the applicant and the medications listed in the application are known by the insurer, or should have been known, at the time of application to be directly related to a medical condition for which coverage would otherwise be denied, the insurer acknowledges that the policy cannot be rescinded for that reason. 52.25(d)(2) • Every insurer or other entity selling or issuing long term care insurance will maintain a record of all policy rescissions, both state and nationwide, except those voluntarily effectuated by the insured and will annually furnish this information to the Superintendent in a format prescribed by NAIC. 52.25(d)(6) • If the policy involves replacement of an existing accident and health policy, a replacement coverage notice that complies with §52.29(d) or (e) will be provided to the applicant PRIOR to issuance or delivery of the policy. The insurer will retain an additional copy signed by the applicant. A direct response insurer will deliver the notice to the applicant at the time of issuance of the policy. <i>Note: Accident and health policies include, but are not limited to, long term care insurance, nursing home insurance only, home care insurance only and nursing home and home care insurance policies.</i> 	
COMBINATION LIFE INSURANCE & LONG TERM CARE INSURANCE			
Combination Products – Joint Life & Health Review		Life Insurance Products that include an Accelerated Death Benefit Rider (ADBR) and an Extension of Benefits Rider (EOBR).	
Life Insurance Policy & ADBR		Both the underlying Life insurance coverage and ADBR are to be approved by the Life Bureau prior to approval of the EOBR by the Health Bureau.	
EOBR		Insurer must submit EOBR for prior approval to the Health Bureau. EOBR is reviewed as stand-alone LTC coverage, and thus must meet all filing requirements for stand-alone LTC coverage.	

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Applications		Insurer must submit applications for combination products for prior approval to both the Life and Health Bureaus.	
Inflation Protection		Insurer must submit ADBR inflation benefits for prior approval to the Life Bureau (DO NOT submit ADBR inflation benefits to the Health Bureau for approval).	
Renewability		EOBR must be renewable, meaning an insured has the right to continue coverage in force by the timely payment of premiums. The insurer has no unilateral right to make any change in any provision of the EOBR while the insurance is in force.	
Rate Requirements		Insurer must submit all EOBR actuarial materials for prior approval to the Health Bureau.	
REVIEW OF PRODUCT OUTLINE			
		In preparing this filing, the insurer or its designated agent reviewed the most current product outline dated / / <i>Note: Insert effective date of product outline.</i>	
NEW PRODUCTS – RATE REQUIREMENTS	11NYCRR52.40(c)(1)	For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below instead.) <i>Complete this section for all forms filings except those filings where a rate filing is unnecessary because: (select one)</i> <input type="checkbox"/> <i>The submission contains only application forms, disclosure statements, and/or advertising, OR</i> <input type="checkbox"/> <i>The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR</i> <input type="checkbox"/> <i>The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</i>	Form/Page/Para Reference
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)	Actuarial qualifications: a. Member of the Society of Actuaries; and b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.	
Justification of Rates	11NYCRR52.40(d)(1)	a. Specific formulas and assumptions used in calculating rates b. Expected claim costs c. Expected lapse rates d. Description of sources of claim costs and lapse rates including all adjustments made and actuarial justification thereof e. Description of rating classes and premium discounts and actuarial justification thereof f. Description of marketing methods g. Expense components of gross premium h. Comparison of the proposed rates with the currently approved rates for similar product(s) with actuarial justification of all variances	

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Loss Ratios	11NYCRR52.40(d)(ix) 11NYCRR52.40(d)(x) 11NYCRR52.45(h)	a. Expected loss ratios by duration and in the aggregate b. Demonstration of expected loss ratios by duration	
Reserve Bases	11NYCRR94(Reg. 56)	Description of bases for active life and claim reserves	
Underwriting	11NYCRR52.40(c)(2)(vii)	Description of general underwriting rules	
Actuarial Certification	11NYCRR52.40(a)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans” as adopted by the Actuarial Standards Board. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory. f. The expected loss ratio is: – % for issue ages 64 and under, – % for issue ages 65 and over, and – % for all issue ages combined.	
ACTIVE RATE MANUAL	11NYCRR52.40(c)(2) 11NYCRR52.25(e)	a. Table of Contents b. Rate pages (2 sets) c. Insurer name on each consecutively numbered rate page d. Identification by form number of each policy, rider, or endorsement to which the rates apply e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits f. Description of rating classes and premium discounts g. Examples of rate calculations h. Commission schedules i. Underwriting guidelines and/or underwriting manual j. Expected loss ratios	
EXISTING PRODUCTS – RATE REQUIREMENTS	11NYCRR52.40(c)(1)	(For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.) <i>Complete this section for all filings of changes in rates (e.g., rate increases/decreases or changes in rate calculation rules or procedures), commissions or underwriting to existing products.</i>	Form/Page/Para Reference
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)	Actuarial qualifications: a. Member of the Society of Actuaries; and b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.	
Justification of Rates	11NYCRR52.40(d)(2)	a. Full description of proposed changes including: (i) Type of changes (ii) Purpose and underlying rationale	

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		<ul style="list-style-type: none"> (iii) Scope of applicability (iv) Limitations and exclusions b. First and last years of issue in New York and date of original form approval c. Loss Ratios: <ul style="list-style-type: none"> • Actual and expected loss ratios by duration and in the aggregate for existing business • Expected loss ratios by duration and in the aggregate for future issues only d. Detailed actuarial justification of the proposed changes <ul style="list-style-type: none"> (i) If rates are not changing: <ul style="list-style-type: none"> (1) Demonstrate impact on loss ratios and/or product profitability (2) Describe handling of existing business (ii) If rates are being revised: <ul style="list-style-type: none"> (1) History of previous New York rate revisions (2) Complete New York experience since inception. If New York experience is not credible, also provide nationwide experience and history of previous non-New York rate revisions as well. (3) Include in (b)(2) above, yearly and in total, collected premiums, paid claims, change in claim reserves, change in active life reserves, earned premiums, incurred claims, cash loss ratio, and incurred loss ratio. (4) Accumulate all items in (3), except reserves, with interest. (5) Describe the basis for active life and claim reserves. (6) If nationwide experience is used where New York experience is not credible, adjust premium items, in (3) above, to the current New York rate schedule. (7) Derivation of the proposed rate revision in detail, including demonstrations that: <ul style="list-style-type: none"> • The expected future loss ratio and expected lifetime loss ratio are at least as large as the disclosure loss ratio, and • The expected future loss ratio is at least as large as the applicable minimum loss ratio per Section 52.45(h) of Regulation 62. (8) A statement that the rates when approved will be applied to all policies delivered or issued for delivery in New York State, regardless of place of current residence. 	
Actuarial Certification	11NYCRR52.40(a)	<ul style="list-style-type: none"> a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans”. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory. f. The expected loss ratio is: <ul style="list-style-type: none"> – % for issue ages 64 and under, – % for issue ages 65 and over, and – % for all issued ages combined. 	

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REVISED RATE MANUAL PAGES	11NYCRR52.40(c)(2)	<ul style="list-style-type: none"> a. Table of Contents b. Rate pages c. Insurer name on each consecutively numbered rate page d. Identification by form number of each policy, rider, or endorsement to which the rates apply e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits f. Description of rating classes g. Examples of rate calculations h. Commission schedules i. Underwriting guidelines and/or underwriting manual j. Expected loss ratio 	

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