NEW YORK INSURANCE DEPARTMENT

Group Long Term Care Insurance Checklist for SERFF Filings (As of 4/12/10) (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. Some items have shaded boxes (e.g., indicating whether the filing is a prefiling). All of the items with shaded boxes must be answered. Some of the items in the checklist require an attachment or explanation. Failure to include required explanations or attachments or an incomplete explanation (such as "not applicable" or "see form") will result in the filing being closed without further review.

E. 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.

F. Do not make any changes or revisions to this checklist.

G. **Checklist Updates:** Any items on the checklist that have been updated since the last posting are shaded.

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

NEW YORK INSURANCE DEPARTMENT
REVIEW STANDARDS FOR GROUP LONG TERM CARE
(TAX-QUALIFIED AND NON-PARTNERSHIP)

LINE OF BUSINESS:	**Group Long Term Care**	LINE(S) OF INSURANCE	CODES
CODE:	**LTC03G**	**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	11NYCRR52.32	The filing is: (select only one) ☐ **Normal submission –** not prefiled group coverage. ☐ **Prefile (select initial or subsequent) -** Group Coverage may be provided prior to the filing or approval of forms provided the conditions contained within §52.32 of Regulation 62 are met. ☐ Initial submission -- must contain: • A copy of the letter of confirmation sent to the policyholder by the insurer. This letter must be submitted to the Department within 30 days after the date the insurer agrees to provide insurance. • The letter must include the effective date of coverage. §52.32(a)(1) • The letter must include the nature and extent of the benefits or change in benefits as then known. §52.32(a)(2) • The letter must set forth the contractual forms may be executed and issued for delivery only after filing with or approval by the Department. §52.32(a)(3) • The letter must set forth that if the forms are not filed or approved or are disapproved, the parties will be returned to the status quo insofar as possible, or the coverage will be modified retroactively to meet all requirements necessary for approval. §52.32(a)(2) ☐ Subsequent submission of forms -- Initial submission dated ___/___/_____, State tracking number _____. • Must be submitted within six months from the date the insurer agrees to provide insurance. §52.32(c)	

		• Failure to meet any of the conditions within the time specified shall be a violation of the insurance law, unless reasons for delay, including its probable extent, satisfactory to the Department are submitted to the Department within the respective times specified.	
Form Requirements	11NYCRR52.12 11NYCRR52.13 11NYCRR52.31 §3102(c)(1)(G)	Each form in the filing must meet the following requirements: 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. *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.* b. This form contains no strikeouts. §52.31(b) c. All blank spaces are filled in with hypothetical data. §52.31(f) 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)	
Explanation of Variables	11NYCRR52.31(l)	If the form contains variable material an explanation of variables must be submitted with this filing in compliance with §52.31(l).	
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.	
Permissible Group	§4235(c)(1)	The policy is issued to one (or more) of the permissible groups set forth in §4235(c)(1).	
Fraternal Benefit Society	§4504(g)	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.	
CONSUMER INFORMATION			
Required Disclosure Form	11NYCRR52.25(c)(6) 11NYCRR52.54(c) 11NYCRR52.65	The filing includes the required disclosure form that: 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/ ENROLLMENT FORMS			Form/Page/Para Reference
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. Note: If the policies are tax-qualified, the caution statement should state "..the company may have the right to deny benefits or rescind your policy.." to be consistent with the incontestability provision required by HIPPA.	
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 within the Department's definition of an extra-hazardous activity, the insurer may elect one of four options: a. The insurer may issue a standard risk policy; b. The insurer may decline to issue any policy at all; c. The insurer may place a waiver on the policy declining coverage for disabilities arising out of such activities; or d. The insurer may charge additional premiums for providing coverage for such activities. If the activity engaged in is not within the definition of an extra-hazardous activity, the Department permits the insurer to issue a standard risk policy or decline to issue any policy at all.	
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". *Note: Does not apply to questions about factual information such as doctor visits or hospital confinements*	
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. *Note: Objective criteria are necessary to avoid unfair discrimination.*	
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: a. The various levels of underwriting. b. The objective criteria used to determine the use of each level of underwriting.	
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	11NYCRR52.51 §3204	The application does NOT contain:	

Provisions		a. Questions as to the applicant's race. b. A provision that changes the terms of the policy to which it is attached. c. A statement that the applicant has not withheld any information or concealed any facts. 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 regarding HIV test results or testing. *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.*	
Telephone or In-Person Interview	§3204 Article III, NY Technology Law	If a telephone or in-person interview will be used with this application, the interview is conducted in the following manner: 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 attached 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 OR 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).	
POLICY FORM	§1117, §3102, §3105, §3201, §3204, §3221 & 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)		
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).	
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	11NYCRR52.18(a)(7) 11NYCRR52.54	If the policy is sold to persons eligible for Medicare (due to age or disability), a notice complying with §52.18(a)(7) is included either on or attached to the cover page of the certificate OR the first page of the disclosure statement required by §52.54.	
Renewibility	§3201(c)(4)	The renewibilty provision must not be misleading to consumers.	
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 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), and 52.12.	
Consumer Price Index	§3201(b)(1), §3201(c)(3), §3204(a)(1), §3217(b), 11NYCRR52.1 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 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 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) and (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.) *Note: Form should not unduly limit the insured's access to benefits.*	
ELIGIBILITY			
Classes of Employees	11NYCRR52.18(f) §4235(c)	If the policy is being issued to an employer group, under 4235(c)(1)(A), the policy may be issued to all employees or classes of employees. The classes of employees are based upon conditions pertaining to employment such as situs of employment, earnings, method of compensation, hours, and occupational duties.	
Dependent Coverage	11NYCRR52.25(b)(4) 11NYCRR52.18(e) §4235(f) Circular Letter No. 27	If dependents are covered under this form: a. Such coverage is in compliance with §4235(f) and §52.18(e). This includes the recognition of marriages between same-sex partners legally performed in other	

	(2008)	jurisdictions. 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 the policy is offering dependent coverage beyond the spouse or domestic partner, the insurer may request a waiver under §1117. This waiver is limited to Parents, Grandparents, or In-Laws. We have not used this waiver to offer eligibility to siblings, aunts or uncles.
Domestic Partner Coverage	§4235(f) OGC Opinion 01-11-23	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. 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. The affidavit must be notarized and require at least the following: • 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.
New Employees/Members	§3221(a)(3)	New employees or members of the class must be added to the class for which they are eligible.
BENEFIT STANDARDS		
Minimum Benefit Coverage	11NYCRR52.12	Minimum long term care coverage **(Select only one)**: ☐ **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 ☐ **Option II** Nursing home and home care coverage at least 60% of reasonable charges ☐ **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. A group policy which offers options, one of which includes at least the benefits set forth in Options I, II or III, may be labeled long term care insurance, however certificates providing coverage that does not comply with §52.12(a) must be labeled nursing home insurance only, home care insurance only or nursing home and home care insurance, as applicable.	
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	If the form provides benefits in addition to the §52.12 required nursing home and home care benefits, the form: 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).	
Rider or Endorsement	11NYCRR52.25(b)(5) 11NYCRR52.18(g)	Only benefits that are reasonably related to long term care coverage may be added by rider or endorsement to policies or certificates providing at least the minimum levels of benefits required by subsection (a) of section 52.12 or subsection (a) or (b) of section 52.13 of this part. Except for riders by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders added to a policy after date of issue which reduce or eliminate coverage in the policy shall provide for signed acceptance by the policyholder.	
Inflation Protection	11NYCRR52.25(c)(3) 11NYCRR52.25(c)(4)	Form offers an inflation protection provision that complies with §52.25(c)(3) of Regulation 62 and pertinent HIPAA and related federal requirements. If the group is an employer, union or professional association the required offer in §52.25(c)(3) of Regulation 62 shall be made to the group policyholder; for all other groups the offering shall be made to each proposed certificate holder.	
Non-forfeiture Benefit	11NYCRR52.25(c)(7) 11NYCRR52.25(c)(8)	Form offers a non-forfeiture benefit at the option of the insured that complies with §52.25(c)(7) of Regulation 62 and pertinent HIPAA and related federal requirements. Where the policy is issued to a group, the above shall be made to the group policyholder if the group is an employer, union or professional association;(for all other groups the offering shall be made to each proposed certificateholder). Note: A contingent Non-forfeiture provision must be offered at the option of the insured, not a default.	
Elimination Period		Form contains an Elimination Period of 180 days or less. *Note: If the insurer proposes an elimination period greater than 180 days, attach a full explanation.*	
International Coverage	11NYCRR52.12 11NYCRR52.13	If the form provides international coverage, the benefits meet or exceed the minimum	

		requirements of long term care. *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*.	
"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. *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*.	
Update Benefits Without Evidence of Good Health		If the form contains a provision to update benefits without evidence of good health (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.	
Extension of Benefits	11NYCRR52.259(b)(3)	Termination of long term care insurance shall be without prejudice to any benefits payable under the policy, rider or certificate if eligibility for such benefits or total disability began while policy was in force and continues without interruption after termination. Such extension of benefits beyond the period of insurance was in force may be limited to the duration of the benefit period, if any, or to the payment of maximum benefits and may be subject to any policy or certificate waiting period, and all other applicable provisions of the policy or certificate, and in the case of home care benefits, may be limited to 12 months.	
Replacement Coverage	11NYCRR52.70(e)(1)	No group policy replacing a plan of similar benefits of another insurer or self-insurer shall be written unless all persons of the same class insured under the prior plan are eligible without evidence of individual insurability or restrictions as to preexisting conditions, except those contained in the policy from which transfer is made to the extent of the lesser of the prior coverage or the coverage provided under the replacing plan.	
Right to Add New Policy (Conversion)	11NYCRR52.25(b)(4)	Termination under the following circumstances shall give rise to elect conversion: divorce or annulment; upon the attainment of the limiting age at which a covered insured's dependent status shall cease; termination of employment or membership in the group; or termination of the group policy or certificate. Such conversion shall be subject to the following: 1) The premium shall be that applicable to the class of risk to which such person belongs, to the age of such person and to the form and amount of insurance. 2) The same or substantially the same benefits and at least as favorable renewal conditions as those contained in the policy or certificate form which conversion is sought. 3) The benefits provided under such policy or certificate shall become effective upon the date that such person was no longer eligible under the previous policy or certificate. 4) No new exclusions may be imposed. 5) The insurer is not required to issue a converted policy to any person who is covered for similar benefits by another insurance policy. In place of conversion, an insurer may offer to insureds covered under a group policy or certificate the right to continue coverage under the group policy or certificate. Such	

		continuation of coverage must comply with §52.25(b)(4).	
Military Suspension of Coverage	§3221(n) Circular Letter No. 7 (2003)	Suspension provision for insureds called to active duty in the armed forces complies with §3221(n). Note: Although no specific time frame to exercise this right is provided in the statute, we suggest using the individual limit of five years, as expresses in §52.17(a)(9) of Regulation 62.	
STANDARD PROVISIONS		*Note: These provisions MUST be included in each policy and must be no less favorable to the insured than the statutory provision.*	
Misstatements	§3221(a)(1)	The policy must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	
Policy Changes	§3221(a)(2)	The policy must provide that no agent has the authority to change the policy or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy, or by amendment to the policy signed by the policyholder and insurer.	
Grace Period	§3221(a)(4)	This policy includes a statement that all premiums due under the policy shall be remitted by the employer or employers of the persons insured or by some other designated person acting on behalf of the association or group insured, to the insurer on or before the due date thereof, with such grace period as may be specified therein.	
Non-Renewal	§3221(a)(5) 11NYCRR 52.18(c)	The policy must specify the conditions under which the insurer may refuse to renew the policy.	
Certificates	§3221(a)(6)	The insurer shall issue either to the employer or person in whose name the policy is issued, for delivery to each member of the insured group, a certificate setting forth in summary form a statement of the essential features of the insurance coverage.	
Age Restrictions	§3221(a)(7)	The policy must state the ages to which the insurance provided shall be limited and the ages for which additional restrictions are placed on benefits, including a description of such additional restrictions.	
Notice of Claim	§3221(a)(8)	The policy must provide that the insured has a minimum of 20 days to provide the insurer with written notice of claim. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	
Proof of Loss	§3221(a)(9)	The policy must provide that the insured has a minimum of 90 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible. *Note: Effective 1/1/11, the insured must have a minimum of 120 days to provide the insurer with proof of loss after the date of such loss.*	
Claim Forms/Filing Proof of Loss	§3221(a)(10)	The policy must provide that the insurer will furnish the insured or the policyholder such forms as are usually furnished for filing proof of loss. If such forms are not furnished before the expiration of fifteen days after the insurer receives notice of the claim, the insured shall be deemed to have complied with the proof of loss requirements upon submitting within the time fixed written proof covering the occurrence, character and extent of the loss for which the claim is made.	
Physical Examination and Autopsy	§3221(a)(11)	The insurer shall have the right and opportunity to examine the insured making a claim as required during the pendency of the claim and the right and opportunity to conduct an	

		autopsy in the case of death unless prohibited by law.	
Payment of Claims	§3221(a)(12)	The policy must provide that benefits payable under the policy other than for benefits for loss of time will be payable not more than sixty days after receipt of proof of loss.	
Loss of Life	§3221(a)(13)	This policy must provide that indemnity for loss of life is payable in accordance with §4235(e). According to §4235(e), the benefits payable under the policy shall be payable to the employee or other insured member of the group or to some beneficiary or beneficiaries designated by him, other than the employer or the association or any officer thereof. If a beneficiary is not designated, then the benefits shall be payable to the estate of the employee or member. The insurer, at its option, may pay such insurance to any one or more of the following surviving relatives of the employee or member: wife, husband, mother, father, child or children, brothers or sisters. Payments so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.	
Legal Actions	§3221(a)(14)	The policy must provide that no action in law or equity shall be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought after the expiration of two years following the time such proof of loss is required by the policy.	
Designation of Beneficiary	§4235(e)	Benefits are payable to the employee or member or a beneficiary designated by such employee or member, other than the employer or association or any officer thereof. If no beneficiary has been designated at the time of the death of the employee or member, then benefits are payable to the estate of the employee or member. The insurer may, at its option, pay such insurance to any one or more of the following surviving relatives of the employee or member: wife, husband, mother, father, child or children, brothers or sisters. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.	
OPTIONAL STANDARD PROVISIONS		*These provisions MAY be included at the insurer's option.*	
Assignment	§3201(c)(3) §3217(b) 11NYCRR52.12	If the form contains an assignment provision, it complies with §§3201(c)(3), 3217(b), and 52.12.	
Benefit Offsets	11NYCRR52.18(d) 11NYCRR52.23	If the insurer wishes to offset the benefits through a non-duplication or coordination of benefits provision, it must comply with §52.18(d) and §52.23 .	
Illegal Occupation	§3221(c) §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. Please refer to §3216(J) for language to be included.	
Intoxicants and Narcotics	§3221(c) §3216(d)(2)(K)	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. Please refer to §3216(K) for language to be included.	
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.	
Subrogation	Chapter 494 of the Laws of 2009	If a subrogation provision is included in this policy or certificate, it must comply with Chapter 494 of the Laws of 2009.	
Return of Premium upon Death	11NYCRR52.16(b)	If the form contains a return of premium on death permitted by §52.16(b), the return of premium is NOT offered as a non-forfeiture benefit.	
PERMISSIBLE EXCLUSIONS &		*No policy shall limit or exclude from coverage by type of illness, accident, treatment or medical condition, with the exception of the following exclusions which may, but are not*	

LIMITATIONS		*required to be included in the policy or certificate.*	
Alcoholism and Drug Addiction	11NYCRR52.25(b)(2)(iii)	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.	
War/Participation in Riot, Felony, or Insurrection/ Service in Armed Forces/ Suicide/Aviation	11NYCRR52.25(b)(2)(iv)	The policy may exclude or limit coverage for illness, treatment, or medical condition arising out of the following situations: 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)	The policy may exclude or limit coverage for services provided by a member of the covered person's immediate family.	
Government Facility	11NYCRR52.25(b)(2)(v)	The policy may exclude or limit coverage for treatment provided in a government facility (unless otherwise required by law).	
Mandatory No-Fault	11NYCRR52.25(b)(2)(v)	The policy may exclude or limit coverage for services for which benefits are provided by any mandatory motor vehicle no-fault law. Note: The term "provided" is permitted, not "payable" or "reimbursable".	
Services for Which No Charge is Normally Made	11NYCRR52.25(b)(2)(v)	The policy may exclude or limit coverage for services for which no charge is normally made in the absence of insurance.	
Medicare or Other Governmental Program	11NYCRR52.25(b)(2)(v)	The policy may exclude or limit coverage for services for which benefits are provided by Medicare or other governmental program (except Medicaid). Note: The term "provided" is permitted, not "payable" or "reimbursable".	
Workers' Compensation	11NYCRR52.25(b)(2)(v)	The policy may exclude or limit coverage for services for which benefits are provided by any state or Federal workers' compensation, employer's liability or occupational disease law. Note: The term "provided" is permitted, not "payable" or "reimbursable".	
Mental or Nervous Disorders	11NYCRR52.25(b)(2)(ii)	The policy may exclude or limit coverage for mental or emotional disorders; however, this shall not permit an exclusion or limitation of benefits on the basis of Alzheimer's disease or demonstrable organic brain disease.	
Coverage Outside U.S. and Possessions	11NYCRR52.25(b)(2)(vi)	The policy may exclude or limit coverage while the insured is outside the United States and its possessions.	
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.	
PROHIBITED EXCLUSIONS AND LIMITATIONS	11NYCRR52.25(c)(1)	A long term care insurance policy may NOT limit or exclude benefits: 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. *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.* 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)** ☐ Unisex basis, OR ☐ Sex-distinct basis and will NOT be issued in any employer/employee situation subject to the Norris decision and/or Title VII of the Civil Rights Act of 1964.	
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			
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)	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)	The schedule page includes space for the insured's name.	
Premium Summary	11NYCRR52.31(f)	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: ☐ indemnity, or ☐ 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: • 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 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 • requiring "substantial supervision" to protect such individual from threats to health and safety due to "severe cognitive impairment" (the Cognitive Impairment trigger). "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). * *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.*	
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. *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.*	
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)	
Incontestability	§4980(c)	As a tax-qualified form, the "Time Limit on Certain Defenses" provision is the three-tiered incontestability provision required by HIPPA.	
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. *Note: This is in addition to the reinstatement provision mandated by §3216(d)(1)(D) of the Insurance Law.*	
Reminders		• 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. *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.* • A copy of the completed application or enrollment form(whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of the application. 52.25(d)(4).	

NEW PRODUCTS – RATE REQUIREMENTS		(For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below instead.) *Complete this section for all forms filings except those filings where a rate filing is unnecessary because: (**select one**)* ☐ *The submission contains only application forms, disclosure statements, and/or advertising, OR* ☐ *The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR* ☐ *The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.*	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	11NYCRR52.25(e) 11NYCRR52.40(e)	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	
Loss Ratios	11NYCRR52.40(e) 11NYCRR52.45(f)	Demonstration that applicable minimum loss ratio will be met	
Reserve Bases	11NYCRR94(Reg. 56)	Description of bases for active life and claim reserves	
Actuarial Certification	11NYCRR52.40(a) 11NYCRR52.45(f) 11NYCRR94(Reg. 56)	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 minimum requirements for Regulation 56 have been met. g. The expected loss ratio is: _____ %	

ACTIVE RATE MANUAL	11NYCRR52.25(e) 11NYCRR52.40(e) 11NYCRR52.40(j)	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 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		(For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.) ***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.***	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	11NYCRR52.25(e) 11NYCRR52.40(e)	a. Full description of proposed changes including: (i) Type of changes (ii) Purpose and underlying rationale (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. (i) Actual and expected loss ratios by duration and in the aggregate for existing business (ii) Expected loss ratios by duration and in the aggregate for future issues only d. Detailed actuarial justification of the proposed changes (i) If rates are not changing: (1) Demonstrate impact on loss ratios and/or product profitability (2) Describe handling of existing business (ii) If rates are being revised: (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: (a) The expected future loss ratio and expected lifetime loss ratio are at least as large as the disclosure loss ratio, and (b) 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) 11NYCRR52.45(f) 11NYCRR94(Reg. 56)	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 minimum requirements for Regulation 56 have been met. g. The expected loss ratio is: %	
REVISED RATE MANUAL PAGES	11NYCRR52.25(e) 11NYCRR52.40(e)	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	