

PRODUCT OUTLINE
INDIVIDUAL BUSINESS OVERHEAD EXPENSE
As of 8/1/03

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I. Key References

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

Key Applicable Regulations – Regulation 62 (11 NYCRR 52) minimum standards for form, content and sale of health insurance including Sections 52.2, 52.8, 52.16, 52.17, 52.31, 52.33, 52.40, 52.41, 52.43, 52.45 (minimum loss ratio standards), 52.51 (applications), 52.53 (conditional receipts/interim insurance agreements), 52.54 and 52.60 (disclosure requirements), Regulation 169 (11 NYCRR 420) privacy of consumer financial and health information including Section 420.18.

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

II. Cover Page

1. Company's Name and Address (New York State licensed entity).
2. Full street address of the company's home office in prominent place (generally front and back of policy form) for disclosure purposes.
3. No unlicensed entity in New York State should appear on the form. – Section 3201(c)(1).
4. Include name of product on the form within the defined category of Section 52.8 of Regulation 62. Since the purpose of a business overhead expense policy is to replace income and revenues lost due to disability which are used to pay overhead expenses, the Department does permit product names such as "Disability Overhead Expense Policy" or "Business Overhead Expense Policy".
5. Include "free look" provision within parameters of Section 3216(c)(10).
6. Form identification number in lower left-hand corner of form – Section 52.31(d).
7. Renewability provisions of form to be placed on the front page of the policy form – Section 52.17(a)(1)(2).
8. If renewability provisions are "noncancellable" and/or "guaranteed renewable", the provisions must comply with Sections 52.17(a)(5)(6)(7) of Regulation 62. In general for business overhead expense forms, the terms "noncancellable" or "noncancellable and guaranteed renewable" can only be used in a form which the insured has the right to continue in force by the timely payment of premiums as set forth in the form until age 65, or as an alternative, until receipt of retirement benefits under the Social Security Act of the United States. During this renewal period, the insurer has no right to make unilaterally any change in any provision of the form while the form is in force. When the term "guaranteed renewable" is to be used alone without using the term "noncancellable" in conjunction with the term "guaranteed renewable", the term "guaranteed renewable" may only be used in a form which the insured has the right to continue in force by the timely payment of premiums until age 65, or as an alternative, until receipt of retirement benefits under the Social Security Act of the United States. During this renewal period, the insurer has no right to make unilaterally any change in any provision of the form while the form is in force except the insurer may make changes in premium rates by classes.

At times the Department has received inquiries from insurers or forms from insurers which give the insurer the right to terminate a "noncancellable" and/or "guaranteed renewable" business overhead expense policy when the reason for the policy no longer exists. For

example, some insurers have desired to terminate a business overhead expense policy when a professional person discontinues his/her office. These insurers indicate they have no reason to keep accepting premium from an insured when such circumstances arise.

The Department would allow an insurer to terminate the coverage when an insured discontinues his/her office (or some similar circumstance pertaining to the need for a business overhead policy) so long as the business overhead policy is not “noncancellable” and/or “guaranteed renewable”. The Department views this reason for termination as a unilateral change which the insurer reserves to nonrenew the business overhead expense policy. Such a reason would have to be prominently set forth in the renewal provision (Section 52.17(a)(1)(2)). Such a renewal provision would preclude the use of a level premium age-at-issue rating methodology with the business overhead expense policy containing such a renewal provision—see below concerning Section 52.40(b)(1). In accordance with Section 3216(f) of the Insurance Law, coverage still has to be provided to the end of any time period for which the insurer has accepted premium or continues to accept premium. Section 52.17(c)(2)(premium refund) would have to be followed as it does with any business overhead expense policy.

The Department adheres to this position because it is favorable to the insured as a consumer protection. When a circumstance arises which affects the reason a business overhead expense policy was purchased (e.g.-professional office discontinuance), the insured may view this circumstance as a temporary situation. The insured might intend to reopen his/her office within a short time period (e.g.-either expecting to recover from the disability or hiring a replacement) and not want to lapse his/her business overhead expense policy or have it unilaterally ended by the insurer. He/she may desire to keep the coverage in force for this brief time interval to retain premium levels at an original younger (and less expensive) issue age or to avoid being medically underwritten again at an older age which could happen if the coverage lapsed with office discontinuance and the insured was compelled to apply for new business overhead coverage upon reopening the office. He/she may desire to keep the coverage in force for this brief time interval to avoid becoming subject to a new pre-existing condition time period which could happen if the coverage lapsed with office discontinuance, and the insured was compelled to apply for new business overhead coverage upon reopening the office. Thus, there are valid consumer protection reasons why an insurer should not unilaterally terminate a business overhead expense policy which is “noncancellable” and/or “guaranteed renewable”.

Some insurers have stated that allowing an insured the sole right to decide whether to terminate business overhead expense coverage when the reason for the coverage no longer exists (e.g.-office discontinuance) is unfair to the insurer even in a “noncancellable” and/or “guaranteed renewable” situation. These insurers indicate some insureds might attempt to submit claims for overhead expenses when the office has been closed for an extended time period, and there are no significant overhead expenses incurred. There appears to be some apprehension by these insurers that a disabled insured will close the office and rely upon coverage to pay fixed expenses such as rent or tenant's insurance with not much incentive to return to full or part time work any time soon. These insurers also appear to be concerned that perhaps variable overhead expenses can be manipulated by an insured in some circumstances so the benefit payments might not all be used for expenses but rather for insured gain. They appear to believe the insurer will be compelled to pay certain overhead expenses in such situations because the insurer cannot unilaterally terminate the business overhead expense policy which is "noncancellable" and/or "guaranteed renewable".

The Department has considered these concerns as raised by some insurers. However, the Department must balance the valid reasons of why an insured purchases a "noncancellable" and/or "guaranteed renewable" business overhead expense policy (see above) and the

possible unjustifiable retention of reserves if an insurer could automatically nonrenew a level premium age-at issue- business overhead expense policy which is "noncancellable" and/or "guaranteed renewable" against those concerns. For example, many times the insurer limits its liability in a business overhead policy by offering only short benefit periods of one or two years. Exposure to the possible abuses by insureds noted above in "noncancellable" and/or "guaranteed renewable" policies with relatively short benefit periods may be overstated by some insurers.

If an insurer offered a "noncancellable" and/or "guaranteed renewable" business overhead expense policy with relatively long benefit periods and the insurer can demonstrate that the above noted coverage manipulation by an insured is possible and frequent, the Department would consider reasonable alternatives to deal with such a problem in a "noncancellable" and/or "guaranteed renewable" business overhead policy. For example, if the insurer with a "noncancellable" and/or "guaranteed renewable" business overhead policy with relatively long benefit periods were to terminate benefit payments after an office was discontinued (but only after a reasonable time period was allowed for payment of "run off" expenses after office closure), the Department would consider such submissions "case by case". Please note that the Department would not allow the insurer to terminate the "noncancellable" and/or "guaranteed renewable" policy, but only terminate benefit payments after office closure with a reasonable time period for "run off" expenses. Perhaps such an approach would strike a reasonable balance between insureds who must close their offices for a short time period (but desire to retain the coverage in force for reasons noted above) and the concerns of some insurers as noted above. The insurer could not terminate the coverage, but the unscrupulous insured desiring to manipulate the "noncancellable and/or "guaranteed renewable" business overhead expense coverage for a longer term would not be receiving benefit payments. Appropriate language to this effect approved by the Department would have to be present in the longer term "noncancellable" and/or "guaranteed renewable" business overhead expense coverage from issuance. It would appear such an approach in a longer term business overhead expense policy would provide an incentive for the unscrupulous insured to lapse the coverage on his/her own because benefit payments over the long term would not be provided after office closure but premium payment would still be required.

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

Section 3216(f) requires that coverage be provided for any time period the insurer accepts premium. Sometimes a business overhead expense form indicates if a person retires or no longer engages in an occupation then coverage ceases immediately upon retirement or cessation of employment (other than by reason of disability). If the insurer has accepted premium for a time period during which retirement or employment cessation occurs, coverage must be provided to the end of the time period. The insurer can base disability benefits on a revised definition (e.g. – insured is unable to perform the usual activities of a person of like age and sex) for any time period when a person has retired or ceases to be employed for a reason other than disability. The insurer needs to take affirmative action in ascertaining whether a person has ceased employment for reasons other than disability or retired to determine whether premium should be accepted.

In keeping with the foregoing paragraph, often business overhead expense policies allow for a period of "conditional renewability" or some right to continue the policy after the "noncancellable" and/or "guaranteed renewability" time period. This period of "conditional renewability" generally arises as of the policy anniversary on or after the insured's 65th

birthday and can vary in length. For example, some insurers allow this conditional renewability period to extend to ages 72 or 75 while others will extend the renewability period for life as long as certain conditions are met.

The conditions for renewability may vary. Generally, the insurer requires the insured to be engaged in some occupation or profession on a full time basis (e.g.-at least 30 hours per week), the insured must be responsible for expenses relating to an office or business and the insured must pay the applicable rates for this time period of renewability. The premium rates payable during this renewability period relating to older ages are almost always able to be raised by the insurer on a class basis.

We emphasize the relevance of Section 3216 (f) of the Insurance Law to the conditions which pertain during this period of conditional renewability. Once premium is accepted to keep coverage effective for a period of time, coverage must be provided for the entire time period involved due to Section 3216(f). The insurer must take affirmative action in ascertaining whether an insured is still responsible for expenses relating to an office or business to determine whether premium should be accepted. The Department will approve policy language through which the insurer reserves a contractual right to require proof from an insured that he/she is still engaged in an occupation or profession and still responsible for the expenses of running an office or business. This language should be reasonable in its scope. For example, a contract provision requiring such proof at renewal time (e.g. through a form sent with a premium billing) would be considered reasonable.

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

III. Policy Schedule Page

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

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

V. Mandatory Standard Contract Provisions

1. Must include “Entire Contract; Changes” provision with no incorporation by reference to writings not part of the form – Section 3216(d)(1)(A), Section 3204(a)(1).
2. Must include “Time Limit on Certain Defenses” provision in accordance with statutory options. Section 3216(d)(1)(B)(i) allows the insurer to have two options regarding application misstatements for an individual business overhead expense policy and the ability

of the insurer to void the policy or deny a claim due to misstatements. The first option allows the insurer to void the policy or deny a claim for loss incurred or disability commencing within the first two years of the policy issuance date on the basis of application misstatements. For fraudulent misstatements in the application, there is no two-year time limit on the ability of the insurer to void the policy or deny a claim for loss incurred or disability commencing from the date of policy issuance. The second option is available only for a policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue. This second option would be available to individual business overhead expense insurers which issue “noncancellable” or “guaranteed renewable” policies within the meaning of Sections 52.17(a)(5)(6)(7) of Regulation 62. This second option requires the insurer to label this option as “Incontestable” and not “Time Limit on Certain Defenses”. This option indicates that, once the policy has been in force for two years during the lifetime of the insured, the policy is incontestable as to any statements contained in the application. At the insurer’s option, the insurer may add a statutory phrase extending the calculation of the two-year period by any period of disability of the insured.

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

Must include a preexisting condition time period complying with Section 3216(d)(1)(B)(ii).

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

Section 3216(d)(1)(B)(ii) indicates that if a disability commences after two years from the coverage issuance date, that disability is not subject to a preexisting condition limitation. Losses payable under business overhead expense coverage unrelated to disability definitions (e.g. – incidental benefits such as hospital indemnity benefits or non-disabling sickness or injury indemnity benefits) have preexisting condition time periods measured from the coverage issuance date, but such losses which occur on a continuous basis during the first two years of coverage must be covered on the 731st day from the coverage issuance date (i.e. – “loss incurred” wording of Section 3216(d)(1)(B)(ii).

Conditions of an insured not considered preexisting conditions within the meaning of Section 52.2(v) are not subject to any preexisting condition limitation. In that instance these conditions would be considered “first manifested” or “first diagnosed or treated” after the coverage issuance date.

3. Must include “Grace Period” provision for premium payment in accordance with statutory options – Section 3216(d)(1)(C).
4. Must include “Reinstatement” provision in case of form lapse in accordance with statutory options. Section 3216(d)(1)(D) of the Insurance Law makes reference to a conditional receipt when premium is tendered with an application for reinstatement. Insurers are reminded that the conditional receipt used for reinstatement of individual business overhead expense forms has its own statutory requirements for use in the reinstatement situation. For example,

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

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

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

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

VI. Optional Standard Provisions

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

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

VII. Permissible Exclusions and Limitations on Coverage*

1. If insurer chooses to place a preexisting condition limitation in the coverage, must comply with Sections 52.16(c)(1) and 52.2(v) of Regulation 62 and Section 3216(d)(1)(B)(ii) of the Insurance Law.
2. If insurer chooses to place an exclusion or limitation on coverage for mental or emotional disorders, alcoholism or drug addiction must comply with Section 52.16(c)(2) of Regulation 62 and Section 3216(d)(2)(K) as pertinent.
3. If insurer chooses to place an exclusion or limitation on coverage for pregnancy, must comply with Section 52.16(c)(3) of Regulation 62.
4. If insurer chooses to place an exclusion or limitation on coverage for war or act of war, suicide, attempted suicide or intentionally self-inflicted injuries, must comply with Section 52.16(c)(4) of Regulation 62.

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

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

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

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

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

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

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

1. If insurer reduces benefits due to an age limit attainment, including a benefit period reduction, such reduction must be referenced on the first page or specification page of the policy – Section 52.17(a)(3) of Regulation 62.
2. If policy contains accident benefits, accident benefits cannot be predicated upon loss occurring through accidental means or violent and external means – Section 52.17(a)(8) of Regulation 62.
3. Insurer must comply with Section 52.17(a)(9) of Regulation 62 and Section 3216(c)(13)(14) of the Insurance Law for insureds entitled to suspend coverage during periods of military service.
4. Insurer attaching any rider or endorsement which reduces or eliminates coverage after policy issuance shall provide for signed acceptance by the insured – Section 52.17(a)(12) of Regulation 62. See also 52.16(e)(2), however, for waivers issued as a condition of issuance, renewal or reinstatement.
5. Riders or endorsements providing a benefit for which a specific premium is charged shall show the premium on the application, rider or elsewhere in the form – Section 52.17(a)(14) of Regulation 62.
6. In general, the form cannot require loss from accidental injury to commence within less than 30 days after the date of an accident – Section 52.17(a)(26) of Regulation 62.

7. In general, any form which the insurer may cancel or refuse to renew cannot require that the form be in force at the time loss commences if the accident occurred while the form was in force – Section 52.17(a)(26) of Regulation 62.
8. Forms based upon attained age shall include the applicable schedule of rates – Section 52.17(a)(29) of Regulation 62.
9. Business overhead expense forms which contain accidental death and dismemberment (AD&D) benefits shall have the AD&D benefits payable if the loss occurs within 90 days from the date of the accident, irrespective of total disability - Section 52.17(b)(1) of Regulation 62.
10. Business overhead expense forms which contain specific accident dismemberment benefits shall not have the specific accident dismemberment benefits payable in lieu of other benefits unless the specific benefit exceeds the other benefit – Section 52.17(b)(3) of Regulation 62.
11. Benefits for specific injury due to accident shall not be in lieu of business overhead benefits, unless the specific benefit exceeds the disability benefit – Section 52.17(c)(1) of Regulation 62.
12. Since a business overhead expense policy limits benefits for disability to specified items, the policy must provide a premium refund, pro rata or in accordance with a short rate table, in the event that none of the specified items to be indemnified exist, but only if the insured gives timely notice. Any premium refund may be limited to a one-year premium. Section 52.17(c)(2) of Regulation 62.
13. No business overhead expense form shall provide for reduction of benefits prior to age 65 by reason of a change in employment status of the insured except in accordance with Sections 3216(d)(2)(A) – Section 52.17(c)(3) of Regulation 62.
14. No business overhead expense form shall reduce benefits solely on the basis of the sex or marital status of the insured – Section 52.17(c)(3) of Regulation 62.
15. Disability benefits conditioned upon hospital confinement shall be considered hospital, medical or surgical expense benefits for purposes of renewability and eligibility under Section 3216 of the Insurance Law and any relevant regulations – Section 52.17(c)(4) of Regulation 62. (This may be applicable when hospital indemnity benefits are a part of business overhead expense coverage)
16. Business overhead expense forms providing disability benefits for dependents shall adequately define the conditions establishing disability – Section 52.17(c)(5) of Regulation 62.

IX. Other Provisions

1. Form definition of “occupation” must be meaningful as used in a business overhead expense policy, fair to the consumer and fully disclosed in the policy language – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.8 of Regulation 62.
2. Form definitions of “disability”, “total disability”, “residual disability”, “concurrent disability”, “recurrent disability”, “partial disability” and similar terms must be meaningful as used in a business overhead expense policy, fair to the consumer and fully disclosed in the policy language – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.8 of Regulation 62.

Business overhead expense forms often contain provisions regarding “recurrent disabilities”, “concurrent disabilities” and terms of similar import. Essentially, the insurer explains in such provisions how the coverage will pay one overhead expense benefit (usually monthly) for a defined disability no matter how many causes (e.g. – how many sicknesses or injuries cause the disability). Such provisions also explain when the insurer deems subsequent disabilities to be related to a prior disability (i.e. – in sum, how much recovery time must elapse before a later disability is eligible for a new benefit period and a new elimination period and is not deemed to be still satisfying an elimination period of a prior disability period or still running out the benefit period of a prior period of disability).

The Department will review such provisions according to the standards noted in Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.8 of Regulation 62.

3. Form definition of “complications of pregnancy” and pregnancy must comply with Section 52.2(e) of Regulation 62, and all pertinent federal statutes, regulations and requirements.
4. Form definitions of consumer price indexes and consumer price index factors able to be used in individual business overhead expense forms must be meaningful as used in a business overhead expense form, fair to the consumer and fully disclosed in the form language. Business overhead expense insurers which reserve the right to change the consumer price index used to calculate policy adjustments in a business overhead expense form should indicate in the form language that any new index chosen by the insurer or change to a present index made by an insurer will be subject to the prior approval of the Superintendent of Insurance (or, as a more general alternative, subject to the approval of the insurance regulatory authority of the state where the form was delivered or issued for delivery when required). An insurer which makes changes in an index or chooses a new index is essentially reserving the right to materially affect future form benefits for which an insured pays premiums based upon an index. This right of an insurer to change an index or choose a new index can make the benefit illusory if the insurer’s action reduces or eliminates form benefits in the future based upon the index. This would be contrary to Section 3201(c)(3) of the Insurance Law. In addition, future changes to a present index or choosing a new index in the future will vary the language of an approved form, and this requires approval of the wording describing the new index or index changes under Section 3201(b)(1) of the Insurance Law. Changes to form language must appear in the contract of insurance under Section 3204(a)(1) of the Insurance Law. – originates from Sections 3201(b)(1), 3201(c)(3), 3204(a)(1), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.8 of Regulation 62.
5. Form definitions of “elimination period”, “waiting period”, or similar provisions which set a time period before overhead expense benefits will be paid must be meaningful as used in a business overhead expense form, fair to the consumer and fully disclosed in the form language – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.8 of Regulation 62.
6. Form definition of “hospital” as used in an individual business overhead expense form must comply with Section 52.2(m) of Regulation 62.
7. Form definitions of “injuries”, “sickness”, “preexisting condition”, “first manifest”, “first diagnosed or treated” or similar terminology must be meaningful as used in a business overhead expense form, fair to the consumer and fully disclosed in the form language – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d), 52.2(v) and 52.8 of Regulation 62.

8. Form definitions of “Covered Overhead Expenses”, “Maximum Overhead Expense Benefit”, “Accumulation Benefit” (ie – some type of “carry forward” mechanism), “Extension of Benefits” and similar terms used to calculate benefits payable under a business overhead expense policy must be meaningful as used in a business overhead expense form, fair to the consumer and fully disclosed in the form language.

For example, business overhead expense policies often vary in the language used to define covered overhead expenses. Usually there is an attempt to list or describe fixed and variable expenses that are usual and customary in the operation of an office or business which would normally be paid from the earnings or revenues generated by an insured who is not generating those earnings or revenues, in whole or in part, due to disability as defined in the policy. Rent, electricity, telephone, heat, water, interest on debt are all illustrations of such expenses, but this is not an all inclusive list.

Similarly, business overhead expense policies often vary in the language used to define or describe overhead expenses that are not covered by the policy. Common overhead expenses which are not covered include salaries, fees, drawing accounts, profit or remuneration for the insured person or person sharing business expenses with an insured person. Such items would not be covered for the insured or a person sharing business expenses with an insured because these items represent income (rather than a business expense) which would be covered by a disability income policy if these persons had purchased a disability income policy.

Some business overhead policies might cover remuneration for a person hired to perform the disabled insured’s duties (replacement) while others might not cover that item or only cover it for an additional premium. The differences appear to be related, in part, to an insurer’s philosophy in handling exposure to disabilities resulting in revenue/earnings losses and benefit payments for covered overhead expenses related to those revenue/earnings losses. It would seem some insurers may view covering the remuneration of a replacement as a method to generate some revenue/earnings while the insured is disabled to mitigate payment of other expenses which would be reduced by the revenues/earnings of the replacement. Other insurers might view the coverage of remuneration for a replacement as a method too much within control of the disabled insured who may own the business. Those insurers may take the view the disabled insured has less incentive to return to work either full time or part time and the claim will be prolonged. So they do not cover remuneration for a replacement or will only cover it for added premium.

The Department will approve reasonable definitions and reasonable descriptions so long as the result is payment of meaningful benefits with a premium rate which is reasonable in relation to those benefits. The foregoing should serve as illustrations of reasonableness.

Similarly, definitions and descriptions of “carry forward” mechanisms as noted above will be approved by the Department so long as they are reasonable and priced appropriately. Often insurers agree to “carry forward” the difference between the maximum monthly overhead expense benefit and the lesser actual monthly covered overhead expenses for any given month of claim. They also agree to “carry forward” the difference between actual monthly covered overhead expense benefits and the maximum monthly overhead expense benefit when actual monthly covered overhead expenses exceed the maximum monthly overhead expense benefit for a given month of claim. Often they agree to such “carry forward” processes on a cumulative basis for a given claim subject to certain time or monetary payout limitations such as a maximum benefit period or a maximum overhead expense benefit. If the policy language provides a meaningful benefit “carry forward” or accumulation for an insured, the Department would approve it. The foregoing should serve as illustrations of what is reasonable and meaningful.

9. Form definitions of “maximum benefit periods”, “benefit periods”, or similar provisions which set a maximum time period for payment of business overhead expense benefits must be meaningful as used in a business overhead expense form, fair to the consumer and fully disclosed in the form language. Reductions in benefit periods due to attainment of age limits must be prominently disclosed by placement on the form face page or specification page – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d), 52.17(a)(3) and 52.8 of Regulation 62.
10. Form definition of “mental disorders” must be meaningful as used in a business overhead expense form, fair to the consumer, and fully disclosed in the form language – originates from Sections 3201(c)(3), Sections 3217(b), 4224(b)(2) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.8 of Regulation 62.
11. Form definition of “physician” or any substitute terms cannot unduly limit access of the insured to business overhead expense benefits under the form – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.8 of Regulation 62.
12. Form provisions dealing with waiver of premium during period of disability resulting from injuries or sickness or assignments must be meaningful as used in a business overhead expense form, fair to the consumer and fully disclosed in the form language – originates from Section 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d), 52.8 and 52.16(b) of Regulation 62.
13. Form provisions which are drafted to provide business overhead benefits using defined form terms must be constructed so as to provide a meaningful benefit amount, for a meaningful time period after any reasonable time delay before benefits are paid. For example, a business overhead expense policy which defines total disability of an insured as being unable to perform the material and substantial duties of your occupation, requiring the regular attendance of a physician and having the disability result from an injury or sickness would be acceptable. However, for a business overhead expense form such a definition should be incorporated into a benefit provision trigger where covered overhead expenses actually incurred for each month are reimbursed for each month of total disability. The reimbursement paid by the insurer during total disability can be after an elimination or waiting period of reasonable duration chosen by an insured (generally no longer than 6 months). The reimbursement paid by the insurer during total disability can be subject to a maximum monthly benefit each month and to an overall reimbursement level determined by a maximum benefit period expressed in time or a cumulative maximum monthly overhead expense benefit expressed in dollar terms. Sometimes the maximum benefit period or cumulative maximum monthly overhead expense benefit concepts are used in the same policy together with an accumulation (e.g.-“carry forward”) concept (see above). Generally, a maximum benefit period of at least one year would be considered reasonable. A reasonable cumulative maximum monthly overhead expense benefit would be arrived at by multiplying the maximum monthly benefit each month (arrived at through choices of the insured as limited by insurer underwriting practices as applied to the actual overhead expenses stated on the insured’s application for business overhead expense coverage) by the general minimum of twelve months. – originates from Section 3201(c)(3) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.8 of Regulation 62.
14. Form provisions which are drafted to provide less than the entire benefit amount for total disability for periods of time when the insured might be able to work part-time or work full-time but not perform all occupational duties (e.g. – residual disability benefits, partial

disability benefits, or similar benefits) must be constructed so as to provide a meaningful benefit amount, for a meaningful time period after any reasonable time delay before less than full form benefits are paid. For example, a business overhead expense policy which defines partial disability of an insured as being able to do one or more but not all of the main duties of your occupation or performing all of your main duties for 50% or less of the time normally required would be acceptable. The policy may require the partial disability to be caused by a sickness or injury, and the policy may also require the insured with the partial disability to be under the regular care and treatment of a physician. Ordinarily the business overhead expense form would incorporate the partial disability definition into a benefit provision trigger where covered overhead expenses actually incurred for each month are reimbursed for each month of partial disability. The reimbursement paid by the insurer during partial disability can be after an elimination period or waiting period of reasonable duration chosen by an insured (generally no longer than 6 months with most insurers giving credit for time elapsed during total disability toward any elimination period or waiting period for partial disability). The reimbursement paid by the insurer during partial disability can be subject to a maximum monthly benefit each month and to an overall reimbursement level determined by a maximum benefit period expressed in time or a cumulative maximum monthly overhead expense benefit expressed in dollar terms. For coverage of covered overhead expense benefits during partial disability, the insurer may choose to cover only a reasonable percentage (e.g. 50%) of the maximum monthly benefit each month or impose other reasonable limits on reimbursement levels appropriate for periods of less than total disability. These lesser reimbursement levels would be acceptable because the partially disabled insured would be expected to generate some earnings/revenues to be used toward covered overhead expenses resulting in less need for the insurance coverage. As a “rule of thumb”, the lesser overall reimbursement levels for partial disability should provide at least 6 months worth of benefits to be considered reasonable whether the benefits are expressed in time periods or dollar terms. The foregoing provides one kind of example, but the Department would consider other reasonable approaches such as those based upon gross monthly revenue, prior gross monthly revenue, current gross monthly revenue and loss of gross monthly revenue. - originates from Section 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.8 of Regulation 62.

15. Form provisions drafted to provide voluntary rehabilitation benefits when the insured and insurer (and some other acceptable parties such as the insured’s medical provider or insured’s immediate family) agree in writing as to the nature of the benefits and amount payable are approvable. In accordance with Section 3201(c)(3) of the Insurance Law, such provisions cannot be drafted to compel an insured to participate in a program for which the insured does not want to participate. The provision as drafted should be constructed to aid the insured in returning to work and to increase the amount of earnings/revenues which an insured can generate for overhead expenses to decrease the need for the coverage.
16. Section 3216(d)(1)(K) is governed by “lead in” wording present in Section 3216(d)(1). The “lead in” wording proscribes approval of language which would be less favorable in any respect to an insured than the wording in Section 3216(d)(1)(K). Section 3216(d)(1)(K) sets forth parameters to allow an insured to bring an action at law or equity in a business overhead expense policy or any individual commercial accident and health insurance policy. Arbitration provisions set forth as a contractual right of an insurer generally preclude an insured from bringing an action at law or equity. Therefore, the Department is under a statutory constraint because arbitration provisions in a policy which preclude an insured from bringing an action at law or equity would be less favorable in many respects to an insured than the parameters set forth in Section 3216(d)(1)(K).

The Department addresses here its statutory inability to approve arbitration provisions in a business overhead expense policy. The Department does not address in this product outline

other reasonable and appropriate mechanisms which an insurer may be able to use in its ongoing relationship with an insured.

17. Generally form provisions are drafted so that an insured can access coverage for covered overhead expenses through a disability rendering the insured unable to perform the material and substantial duties of their own occupation. We believe that insurers generally adhere to this wording because they desire to be certain of the covered overhead expenses and need for business overhead coverage associated with the specific occupation of the insured at issuance and throughout any disability. It appears possible that a dual definition (e.g. disabled from their own occupation and, after a time period, disabled from any occupation for which the insured is fitted by reason of education, experience or training) could be used in a business overhead expense policy, however, the insurer would have an uncertainty as to the overhead expenses associated with a later occupation and not necessarily be certain that a later occupation would require an office or business at all (e.g a doctor who is a disabled surgeon becomes an internist with differing equipment, personnel costs in the office or a doctor who is a surgeon becomes a medical school professor with no need for an office at all). The Department would review and approve reasonable structures in a business overhead policy.— originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.8 of Regulation 62.

18. Form provisions providing update increases or future guaranteed option increase dates or events where business overhead expense benefits are automatically increased without evidence of good health upon payment of proper premium are approvable in general.

The Department would allow a reasonable number of times for such increase to occur for an appropriate premium.

The Department would allow an insurer to use reasonable methods to protect itself against anti-selection and to encourage insureds to opt for increases without evidence of good health when still relatively healthy. However, limiting an insured to maximum increase amounts based upon undefined issue and participation limits in effect at some future date would make the benefit illusory. The insurer could adversely change its issue and participation limits in the future to limit or eliminate the insured's ability to increase business overhead expense benefits without evidence of good health. An insurer should guarantee its issue and participation limits in effect when the benefit providing increases without evidence of good health is issued so the benefit is not illusory. – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.8 of Regulation 62.

19. Form provisions which coordinate or integrate business overhead expense benefits with benefits payable from other individual or group health or business overhead expense policies are not approvable in New York State for use in individual business overhead expense forms – Section 52.23(e)(3)(i) of Regulation 62.

20. The Department notes that business overhead expense insurers often include conversion privileges in their policies to permit insureds to convert to individual disability income policies. This feature is not required by statute or regulation, but it appears to be a mechanism to allow insureds with changing needs for coverage of disabilities to retain coverage with the same insurer. An insured who permanently closes an office or business, but now is employed by another business may need to cover his/her income from losses due to disability. The change in status from self-employment to general employment may occur at an older age when premiums are higher and/or medical conditions complicate the underwriting process. Therefore, the Department will approve conversion privilege language in business overhead policies which is reasonable. For example, allowing conversion from business overhead coverage to disability income coverage before age 60 without evidence of

medical insurability so long as the insured is not disabled at conversion time is reasonable. Further conditions considered to be reasonable are: limiting the disability income policy maximum benefit period to 2 years, limiting the waiting period of the disability income policy to one as long or longer than the waiting period of the business overhead coverage, indicating the maximum monthly benefit of the new disability income policy when added to the amount of disability income coverage in force with all companies at time of conversion does not exceed published issue and participation limits in effect for disability income coverage in effect at issuance of the business overhead expense policy (unless future changes in those issue and participation limits after issuance of the business overhead expense policy are more favorable to the insured at time of conversion).

21. Policies which limit benefits for disability to specified items such as a business overhead expense policy must provide for a premium refund, pro rata or in accordance with a short rate table, in the event that none of the items to be indemnified exist as when an office or business closes. The policy language may require the insured to give timely notice that the items to be indemnified no longer exist, and the insurer may limit premium refund to a one year premium. – Section 52.17(c)(2)
22. Earlier in this outline (IX., 8.) an example was given of how business overhead expense insurers differ in the type of covered overhead expenses which they always cover and those covered overhead expenses excluded or covered for additional premium. Due to Section 3217(b)(5) of the Insurance Law and Section 52.1(c) of Regulation 62, the Department will not approve business overhead expense policies which unduly attempt to fragment the risk insured by a business overhead expense policy. If an insurer began to exclude coverage of certain covered overhead expenses normally incurred in the operation of a business or office and only made them available as optional coverages for added premium, the Department would be concerned with undue fragmentation.

Such an approach in a business overhead expense policy would allow an insurer to provide a policy which did not meet the basic needs of an insured operating a business or office when that insured did not purchase the optional benefits. In addition, offering certain covered overhead expenses normally incurred in the operation of an office or business only on an optional basis for added premium would allow the insurer to charge more (e.g. added underwriting and administrative costs when optional benefits integral to the operation of an office or business are offered on an optional basis) than would be the case if the basic overhead expenses were included in a more comprehensive business overhead policy as usual coverage.

Therefore, insurers should always include overhead expenses normally incurred in the operation of an office or business in the basic policy structure of a business overhead policy as usual benefits. This will avoid Department comments about fragmentation and expedite the approval process.

23. Insurers in the individual business overhead expense market are reminded of their obligations under Section 3228 of the Insurance Law.

X. Applications

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

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

2. Section 52.51(a) of Regulation 62 requires that an application cannot contain questions as to race of the applicant.
3. Section 52.51(b) of Regulation 62 requires that questions regarding past or present health of any person that refers to a specific disease or general health must be asked to the best of the applicant's knowledge and belief. Questions regarding factual information, such as doctor's visits or hospital confinements, do not require this qualification.
4. Section 52.51(c) of Regulation 62 requires that no application will contain a provision that changes the terms of the policy to which it is attached.
5. Section 52.51(d) of Regulation 62 requires that no application will contain a statement that the applicant has not withheld any information or concealed any facts.
6. Section 52.51(e) of Regulation 62 requires that no application will contain an agreement that an untrue or false answer material to the risk shall render the contract void.
7. Section 52.51(f) of Regulation 62 requires that no application will contain an agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except in conformity with Section 3204 of the Insurance Law.
8. Section 52.51(g) of Regulation 62 requires that applications for conversion policies may not contain questions as to the health of the person or persons entitled to conversion.
9. Section 52.51(h) of Regulation 62 requires that applications for policies subject to Section 3216(d)(2)(D) or (E), "Insurance with Other Insurers", will contain a question or questions requiring information with respect to such other insurance.
10. Section 52.51(i) of Regulation 62 requires that if an insurer includes in a policy the optional standard provision under Section 3216(d)(2)(C), "Other Insurance in this Insurer", a statement describing the provision in the policy must be included in the application, or provided at the time of application by separate notice.
11. Section 52.51(j) of Regulation 62 requires that if a policy contains a provision with respect to "pre-existing conditions", a statement describing the policy provision must be included in the application

OR provided at the time of application by delivery of the disclosure statement required by Section 52.54.

12. Previous HIV test results are NOT questioned, sought or used per Sections 3217(b) and 52.1 of Regulation 62. Information regarding the diagnosis or treatment of AIDS or ARC may be sought and used. Also, the insurer has the right to conduct its own medical tests as part of the underwriting process.
13. Individual business overhead expense insurers are reminded of their obligations under Section 2611 of the Insurance Law and Section 2782 of the Public Health Law regarding written informed consent, authorization and disclosure of confidential information when the insurer uses an HIV antibody test in underwriting. Circular Letters No. 3 (1989) and No. 5 (1997) are relevant.
14. If this filing contains a reference to a telephone or in-person interview, the interview is conducted in the following manner:

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

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

Any information obtained in the interview that will be used in the underwriting process will be reduced to writing, signed by the applicant and attached to the policy in compliance with Section 3204 of the Insurance Law.
15. If an Investigative Consumer Report will be prepared or procured, the insurer complies with Section 380-c of the General Business Law by providing notice in the application or in a separate form.
16. If a Medical Information Exchange Center (such as a Medical Information Bureau) will be used, the insurer complies with Section 321 of the Insurance Law.
17. Section 420.18(b) of Regulation 169 requires that an authorization to disclose nonpublic personal health information specifies the length of time the authorization will remain valid (maximum 24 months).
18. Section 403(d) of the Insurance Law requires a fraud warning on the application form.
19. Section 3204 of the Insurance Law contains requirements that apply to application forms for individual business overhead expense insurance policies. An insurer may make insertions for administrative purposes only as long as the insertions are clearly not ascribed to the applicant. No other insertions or alterations of a written application will be made by anyone other than the applicant without his written consent.

XI. Disclosure Requirements

1. Sections 52.54 and 52.60 of Regulation 62 set forth disclosure requirements which apply to individual business overhead expense policies.

XII. Marketing of Individual Business Overhead Expense Insurance Using Group Methods

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

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

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

Based upon the foregoing, the individual business overhead expense insurance checklist has set forth the mechanisms through which individual business overhead expense insurance products can be marketed using group or quasi-group methods. The first method which is a step toward group or quasi-group methods is a payroll deduction arrangement. When this arrangement is used for premium payments with no discounts at all and no other type of group or quasi-group methods, the individual business overhead expense product remains subject to regulation as an individual product. No group or quasi-group savings

or advantages to any significant degree are claimed by the insurer, and the individual insured has the convenience of payroll deduction as long as the employer is willing to provide that convenience. Here the insurer will accept premium payments directly from an insured should the insured lose the convenience of payroll deduction or choose not to use payroll deduction to pay premiums. In the business overhead expense situation, this arrangement might occur for a business owner who is an employee of a small corporation.

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

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

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

A “list bill” situation involving business overhead expense insurance might involve several policies sold to partners of one business or members of a limited liability company to cover each partner’s or member’s share of covered overhead expenses in the business. The relevance of a “list bill” situation going out of existence might happen when one partner or member leaves a business to join or start another business on his/her own and desires to pay premiums for the business overhead policy on a direct bill basis. This paragraph is citing a possible example while other situations might be possible as well.

The third method which is the last method and the most expansive method of marketing or offering individual business overhead expense insurance products with group or quasi-group savings or advantages is franchise insurance. Sections 52.2(k), 52.19 and 52.70 of Regulation 62 (11NYCRR52) should be consulted. Generally, individual business overhead expense insurance products are distributed on a mass merchandising basis, administered by group methods and provided with or without evidence of insurability. Sponsorship by an employer or association occurs and exclusivity in the marketing of the individual products is granted to a particular insurer. The individual contract mechanism is retained. So the legal relationship is directly between the insured and insurer with no group policy being issued to a

group policyholder. However, the insurer is generally able to know beforehand the characteristics of the insureds (e.g. – bar association, medical society, etc.), and the insurer is generally able to obtain a significant number of insureds due to the sponsorship of the employer or association, exclusivity granted to the insurer in marketing the individual business overhead expense insurance product and more sizeable discounts for the insured. We are just short of marketing the product as group under New York law, but the employer or association does not enter the direct legal relationship of the insurance contract and is not the group policyholder.

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

In the employer franchise business overhead expense situation, a corporate employer might sponsor and endorse the business overhead expense product of one insurer for all partners or members of the corporate employer sharing covered overhead expenses. In the association franchise business overhead expense situation, a bar association or medical society might sponsor and endorse the business overhead expense product of one insurer for its members with law offices or medical offices. The relevance of the continuation of a franchise discount might happen when a lawyer or doctor ends membership in an association or society but desires to continue the coverage on his/her own. This paragraph cites possible examples while other situations might be possible as well.

XIII. Conditional Receipts/Interim Insurance Agreements

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

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

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

The required premium has been paid.

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

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

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

Suppose a business overhead expense applicant pays premium with his/her application, and the insurer issues a conditional receipt to the applicant on December 1, 2002. The applicant completes all parts of the application truthfully on December 1, 2002, and the applicant awaits the insurer's underwriting decision. Then assume on December 8, 2002 (which is before the expiration of a 60 day time limit in the receipt), the applicant is diagnosed with a severe condition causing disability which would be covered under the business overhead expense policy applied for (but not yet issued because the insurer is in the process of underwriting). The applicant begins to incur covered overhead expenses on December 15, 2002. Then assume the applicant dies on January 27, 2003. The insurer would be using its underwriting rules in effect on December 1, 2002, and the insurer would be assessing the insured's health as of December 1, 2002 based upon a truthful application submitted by the applicant on December 1, 2002. The insurer would issue a business overhead expense policy dated effective December 1, 2002. If the business overhead expense policy issued had a 0-day waiting period for covered overhead expenses, the insurer would be obligated to pay for covered overhead expenses incurred according to policy terms from December 15, 2002 until January 27, 2003. This might all occur retrospectively if the insurer used the full 60 day period mentioned in the conditional receipt and did not issue the business overhead expense policy with a December 1, 2002 effective date until January 29, 2003.

3. An interim insurance agreement provides some type of immediate limited insurance coverage as of the application date. The agreement provides coverage in accordance with the policy and plan of insurance described in the application subject to any reasonable limit regarding the amount or

duration of insurance specified in the agreement. Coverage is provided as of the application date and must provide at least 60 days coverage unless:

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

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

4. An insurer may honor a written request from the applicant that coverage begins as of a specified date later than the date provided for in the conditional receipt or interim insurance agreement. In other than replacement situations, the applicant's written request for a later effective date must contain a statement signed by the applicant that he/she understands that he/she may be waiving certain rights and guarantees under the conditional receipt or interim insurance agreement. Section 52.53(f) of Regulation 62.
5. If coverage is provided under a conditional receipt or interim insurance agreement for two or more proposed insureds, the coverage must be determined separately for each proposed insured, except, however, all proposed insureds may be rejected in the event of fraud or material misrepresentations. Section 52.53(d) of Regulation 62.
6. If a policy is not issued within the time specified in the conditional receipt or interim insurance agreement, the application will be deemed rejected and all premiums will be refunded. Section 52.53(i) of Regulation 62.
7. In mail order cases only, an insurer may postpone the effective date of coverage to the date of issuance of the policy. Section 52.53(g) of Regulation 62.
8. In franchise cases, the coverage under the conditional receipt or interim insurance agreement may be made contingent upon meeting specified participation requirements. Section 52.53(h) of Regulation 62.

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

XIV. Rating Procedures and Requirements

1. Section 52.40(a) of Regulation 62 sets forth general procedures and requirements which apply to the rating of business overhead expense forms.
2. Section 52.40(b) of Regulation 62 sets forth prohibited rating practices which may be applicable to business overhead expense forms.

3. Section 52.40(c) of Regulation 62 sets forth requirements applicable to individual business overhead expense forms.
4. Section 52.40(d) of Regulation 62 sets forth requirements applicable to individual business overhead expense forms.
5. Section 52.41 of Regulation 62 sets forth gross premium differentials based on sex which apply to individual business overhead expense forms.
6. Section 52.43(a) of Regulation 62 sets forth standards for maintaining experience data which apply to individual business overhead expense forms.
7. Section 52.44(b) of Regulation 62 sets forth monitoring standards which apply to individual business overhead expense forms.
8. Section 52.45(a),(c),(d) and (e) of Regulation 62 sets forth minimum loss ratio standards which apply to individual business overhead expense forms.