Group Specified Disease Coverage Checklist for SERFF Filings (As of February 17, 2022) Non-Recurring (Lump Sum)

Instructions for SERFF Checklist:

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

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

Policy – Also complete the "Policy Form" section.

Rider or endorsement – Also complete all items in the "Policy Form" section relevant to the form being submitted.

Application – Also complete the "Application Forms" section.

C. For filing of **RATES** for NEW products, complete the "New Products – Rate Requirements" section in addition to completion of the applicable form sections identified above. For filing of **RATE** changes to EXISTING products (increases, decreases, or change in rate calculation rules or procedures), complete the "Existing Products-Rate Requirements" section. For filing of any OTHER changes to **RATE** or underwriting manuals (e.g., changes in commissions or underwriting), complete the "Existing Products-Rate Requirements" section.

D. For each item, enter in the last column the form number(s), page number(s) and paragraph(s) where the requirement is met in the filing or insert a bookmark connecting to the appropriate location in the filing. All items with shaded boxes must be answered.

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

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

LINE OF BUSINESS:	**Group Health-Specified Disease-Limited Benefit (Non-Recurring)**	LINE(S) OF INSURANCE	CODES
CODE:	**H07G**	**Critical Illness**	H07G.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 Description in SERFF	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	The SERFF filing description must contain the following: • The identifying form number of each form submitted. § 52.33(a) • If the form being submitted is a policy, the filing description must indicate that the policy is submitted pursuant to 11 NYCRR 52.15(a). § 52.33(b) • Whether the form is new or supersedes an approved or filed form. § 52.33(c) • If the form supersedes an approved or filed form, the filing description must state the form number and date of approval or filing of the superseded form and any material differences from the superseded form. § 52.33(d) • If the approval of the superseded form is still pending, the filing description must include the state tracking number, form number, and the submission date. § 52.33(d) • If the form had previously been submitted for preliminary review, the filing description must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission or the differences from the form submitted for preliminary review. § 52.33(e) • If the form is submitted in accordance with 11 NYCRR 52.32(c), the filing description must identify the prefiled group coverage. § 52.33(f) • If the form is other than a policy, the filing description must identify the form number and approval date of the policy or policies with which it will be used. If the form is for general use, the Department may accept a description of the type of policy with which it may be used in lieu of the form number and approval date. § 52.33(g) • If the form is a policy, the filing description must identify the form numbers and dates of approval of any applications previously approved to be used with the policy unless the application is	

		required to be attached to the policy upon submission. § 52.33(h) • If the policy is designed to be used with insert pages, the filing description must contain a statement of the insert page forms which must always be included in the policy and a list of all optional pages, together with an explanation of their use. § 52.33(i) *Note: SERFF filing descriptions should advise as to whether the policy is intended for internet sales..*	
Form Requirements	§ 3201(c) § 3217(b) 11 NYCRR 52.1(c) 11 NYCRR 52.31	Each form in the filing must meet the following requirements: • The form provisions are NOT misleading or unreasonably confusing. § 3217(b)(2), § 52.1(c) • The form provisions provide substantial economic value to the insured. § 3217(b)(5), § 52.1(c) • The form provisions are NOT unjust, unfair, inequitable, misleading, or deceptive to the policyholder. §§ 3201(c)(3), 3217(b) • The form contains no strikeouts. § 52.31(b) • The form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. § 52.31(d) • The form is submitted in the form intended for actual use. § 52.31(e) • All blank spaces are filled in with hypothetical data. § 52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. A full explanation of the nature and scope of the variable material, contained in an Explanation or Memorandum of Variable Material, should be uploaded to the Supporting Documentation tab in SERFF. § 52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable if suitably indicated by red ink, bracketing or underlining, and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as “will conform to law” or “as requested by policyholder” to describe the variable material. § 52.31(l)	
Discrimination	§ 2606 § 2607 § 2608 § 2612 Circular Letter No. 3 (2016)	No insurer or entity shall refuse to issue any insurance policy, or cancel or decline to renew the policy or otherwise unfairly discriminate because of race, color, creed, national origin, disability, sex, marital status, status as a victim of domestic violence, or engage in sexual stereotyping. “Sex” includes sexual orientation, gender identity or expression and transgender status. No insurer or entity shall refuse to issue or renew, or shall cancel any insurance policy because of any past treatment for a mental disability of the insured. With respect to past treatment for a mental disability, an issuer may refuse to issue, renew, or cancel a policy if the issuer relies on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience.	
Flesch Score	§3102(c)	Provide Flesch score certification (the Flesch score should be at least 45). The number of words, sentences and syllables in the form should be set forth as part of the certification, which must be signed by an officer of the company.	
Table of Contents	§ 3102(c)(1)(G)	A table of contents is required for policies that are over 3,000 words or more than 3 pages regardless of the number of words.	

Group Status and Recognition	§ 4235 § 3201(b)(1) 11 NYCRR 59	The SERFF filing description should include a statement that policy forms will be sold to a group specified in Insurance Law § 4235(c)(1). However, a more detailed statement must be included where discretionary group status is sought under Insurance Law § 4235(c)(1)(M). See below. The size of the group should be indicated (small, large or both). The SERFF filing description should indicate whether the submission is for general use or is submitted on a single case basis. If the submission is for use on a one case basis, the group must be identified along with the subpart of Insurance Law § 4235(c)(1) in which the group fits and a confirmation that the group meets all of the requirements of the identified subpart. Requests for discretionary group recognition must be accompanied by written documentation that demonstrates that the proposed group meets every element stated in the named statute. The documentation must also make clear that the request for discretionary group recognition is not a subterfuge, evasion technique, or a marketing tool to avoid compliance with other statutory or regulatory requirements and recognized marketing mechanisms. This provision is not intended to allow approval of groups recognized in the various subparagraphs of Insurance Law §§ 4235(c)(1) or 4237(a)(3), but for which the proposed discretionary group does not meet one or more of the requisites specifically required by Insurance Law §§ 4235 or 4237. The request for allowance of a discretionary group must be granted before a policy may be issued to a discretionary group. Pursuant to Insurance Law § 3201(b)(1) and Insurance Regulation 123 (11 NYCRR Part 59), an accident and health certificate is deemed delivered in New York and subject to the Department's review and approval regardless of the actual place of delivery, if the policy is issued to one of the following groups: • § 4235(c)(1)(D), a policy is issued to a trustee or trustees of a fund established, or participated in, by two or more employers not in the same industry with respect to an employer principally located within New York; • § 4235(c)(1)(K), a policy issued to an association; • § 4235(c)(1)(L), a policy issued to a bank, retailer or other issuer of a credit card to insure holders of the credit card; or a bank, savings and loan association, credit union, mutual fund, money market fund, stockbroker or other similar financial institution regulated by state or federal law to insure the depositors, account holders, or members of that financial institution; • § 4235(c)(1)(M), a policy issued to a discretionary group as approved by the Superintendent; or • Any groups not recognized in Insurance Law §§ 4235(c)(1) or 4237(a)(3). The group certificate is reviewed for compliance with New York Law. The group policy that is delivered out-of-state is not reviewed.	
Rider or Endorsement	11 NYCRR 52.16(e)(2) 11 NYCRR 52.18(g)(2) 11 NYCRR 52.31(a)	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. New policy forms must comply with any statutory requirements without the use of amendatory riders or endorsements except for minor changes. Previously approved policies may have riders attached to comply with New York law, but only if it does not cause the policy in its entirety to mislead or confuse the policyholder. § 52.31(a) Note: For waivers issued as a condition of insurance, renewal or reinstatement, see 11 NYCRR	

		52.16(e)(2)	
CONSUMER INFORMATION			
Required Disclosure Form	11 NYCRR 52.15(b)(5) 11 NYCRR 52.66	This filing contains the required disclosure form per §§52.15(b)(5) and 52.66 of Regulation 62 to be delivered to the applicant at the time application is made and receipt is acknowledged. *Note: Two formats exist – The disclosure required for persons under age 65 is in 11 NCYRR 52.66(a) and the and one for persons age 65 or older is in 11 NYCRR 52.66(b).. Insurers must deliver the required disclosure form at the time the policy is delivered.*	
APPLICATION FORMS			Form/Page/Para Reference
Authorization	11 NYCRR 420.18 Circular Letter No. 8 (2017) 42 USC § 290dd-2 42 CFR § 2.31	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months. A written authorization that consents to a disclosure of substance use disorder records must include: (1) the specific name or general designation of the program or person permitted to make the disclosure; (2) the name or title of the individual or the name of the organization to which disclosure is to be made; (3) the name of the patient; (4) the purpose of the disclosure; (5) how much and what kind of information is to be disclosed; (6) the signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under 42 C.F.R. § 2.14 or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under 42 C.F.R. § 2.15 on behalf of the patient; (7) the date on which the consent is signed; (8) a statement that the consent is subject to revocation at any time except to the extent that the program or person that is to make the disclosure has already acted in reliance on it, where acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; and (9) the date, event or condition upon which the consent will expire if not revoked before that date, event or condition.	
Electronic Application	§ 3201(c)(3) 11 NYCRR 52.1(c) State Technology Law Article III 9 NYCRR Part 540	If an insurer is seeking approval to use a previously approved paper application in electronic format, screen shots of the previously approved paper application must be filed for reference for informational purposes. Any drop downs, pop-ups, FAQs, or linked material that could appear in the application process must be included either within the screen shots or as a supporting document provided for informational purposes. If an insurer is seeking approval of an application not previously approved that will only be available in an electronic format (i.e., will be completed and signed electronically) and there is no corresponding paper application, then screen shots must be submitted for approval as the application form. In this case, the screen shots must contain a distinct form number in the lower left corner and must comply with all applicable application requirements. Reflexive material, including drop down options, must be submitted for approval in a corresponding Explanation of Variable Material. Include any pop-ups, FAQs, or linked material that could appear in the application process as a supporting document provided for informational purposes. If an electronic signature is used, it must comply with the Electronic Signatures and Records Act	

		(State Technology Law Article III) and associated regulations (9 NYCRR Part 540). The filing should describe the procedures for the use of electronic signatures.	
Electronic Delivery of Documents	State Technology Law Article III OGC Opinion No. 09-01-01 OGC Opinion No. 05-11-28	Before an insurer transmits policy forms or any other documents to an insured electronically, it must obtain the insured's consent. • If the electronic application includes a consent for the electronic delivery of documents, the opt-in to deliver documents electronically must be separate from the agreement to electronically purchase and/or electronic signature. • If the insured refuses to consent to receiving documents electronically, the insurer must send a hard copy of the policy forms or other documents to that insured. If the insured refuses to consent to receiving documents electronically, the insurer should allow the insured the ability to proceed with submitting the application and purchasing the insurance electronically.	
Extra-hazardous Activities	§ 1113(a)(17)(E) 11 NYCRR 52.2(i) 11 NYCRR 52.16(e)(2)	If the application contains questions as to whether the applicant has engaged in or contemplates participation in a number of specified activities, the insurer will adhere to the following Regulation 62 guidelines regarding "extra-hazardous" activities, defined by 11 NYCRR 52.2(i) as aviation and related activities, such as sky diving and parachuting, and participation as a professional in athletics or sports. Participation as a professional in athletics or sports means an individual who would qualify for insurance under Insurance Law § 1113(a)(17)(E). An insurer may exercise the following options depending upon whether the activity engaged in by the applicant is an extra-hazardous activity as defined by 11 NYCRR 52.2(i). If the activity engaged in by the applicant is within the definition of an extra-hazardous activity, the insurer may elect one of four options: 1. The insurer may issue a standard risk policy; 2. The insurer may decline to issue any policy at all; 3. The insurer may place a waiver, approved by the Department, on the policy declining coverage for accidents arising out of such activities; or 4. The insurer may charge additional premiums for providing coverage for such activities. If the activity engaged in is not within the definition of an extra-hazardous activity, the insurer must issue a standard risk policy or decline to issue any policy at all. *Note: Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required, unless on initial issuance the full text of the extra-hazardous activity exclusion is contained either on the first page or specification page of the policy. For additional information, see the "Extra-hazardous Activities" section under "Permissible Exclusions and Limitations."*	
Fraud Warning Statement	§ 403(d) 11 NYCRR 86.4(a), (d)	The application form contains the prescribed fraud warning statement listed below. The fraud warning statement must be placed directly above the signature line and printed in such a way that it is conspicuous to the insured such as by using bold font or larger font size. "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed	

		five thousand dollars and the stated value of the claim for each such violation."	
Future Activities	11 NYCRR 52.1(c)	Applications should not inquire about open ended future activities or the future intent of the applicant (such as asking if the insured ever plans on leaving the country) as these are unduly speculative. Questions should be limited to present intent or present plans.	
Health Questions	11 NYCRR 52.51(b)	Any question of past or present health of any person that refers to a specific disease or general health must be asked "to the best of the applicant's knowledge and belief." This does not apply to questions about factual information such as doctor visits or hospital confinements. *Note: The application should phrase each question with respect to this statement; or, in the alternative, a sentence that states that "the following questions are asked to the best of the applicant's knowledge and belief." may be added to the beginning of any application section that includes questions regarding a specific disease or general health.*	
Investigative Consumer Report	General Business Law § 380-c	If an Investigative Consumer Report will be prepared or procured, a notice and authorization complying with General Business Law § 380-c is included in the application OR in a separate form.	
Medical Information Exchange Center	§ 321	If the insurer will transmit medical information from an applicant for personal insurance to a Medical Information Exchange Center (such as a Medical Information Bureau) or other similar facility, the insurer must provide a clear and conspicuous notice disclosing: • A description of the Medical Information Exchange Center or other facility and is operations, including its name, address and telephone number where it may be contacted to request disclosure of any medical information transmitted to it; • The circumstances under which the Medical Information Exchange Center or other facility may release such medical information to other persons; and Such applicant's right to request the Medical Information Exchange Center or other facility to arrange disclosure of the nature and substance of any information in its files pertaining to them, and to seek correction of any inaccuracies or incompleteness of such information.	
Multiple 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; and b. The objective criteria used to determine the use of each level of underwriting.	
Overinsurance	11 NYCRR 52.15(b)(15)(i) 11 NYCRR 52.15(b)(15(ii)	The application includes questions to: a. Elicit whether, as of the date of the application, the applicant has coverage in force or application(s) pending for another specified disease policy or certificate for the <u>same</u> specified disease <u>with the same or a different insurer</u>. §52.15(b)(15)(i). b. Elicit the <u>number</u> of specified diseases for which either the applicant has coverage in force as of the date of the application <u>or</u> application(s) pending as of the date of the application. §52.15(b)(15)(ii).	
Pre-Existing Conditions	11 NYCRR 52.51(j) 11 NYCRR 52.54	If the application is used with a policy that contains a "pre-existing conditions" provision, a statement describing the policy provision is included in the application OR the statement is included in the disclosure statement required by 11 NYCRR 52.54 that is delivered at the time of application.	
Prohibited Questions and Provisions	§ 3204 11 NYCRR 52.51	The application does NOT contain: • Questions regarding the applicant's race.	

		• A provision that changes the terms of the policy to which it is attached. • A statement that the applicant has not withheld any information or concealed any facts. • An agreement that an untrue or false answer material to the risk will render the policy void. • An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to Insurance Law § 3204(d). • Questions regarding HIV, such as HIV testing, test results, or treatment. *Note: Information regarding the diagnosis or treatment of AIDS may be sought and used. The insurer has the right to review medical records or conduct its own medical records as part of the underwriting process. References to AIDS Related Complex (ARC) should also not be used as the terminology has been discontinued in the medical community.*	
Representations not Warranties	§ 3105 § 3204(c), (d)	Statements made on the application by the applicant are representations and not warranties, and only material misrepresentations can avoid a contract of insurance. No representation is deemed material unless knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to issue the policy. *Note: The insurer may make insertions to the application only for administrative purposes if the insertions are clearly not ascribed to the applicant. No other insertions or alterations of a written application will be made by anyone other than the applicant without the applicant's written consent pursuant to Insurance Law § 3204(d).*	
Telephone or In-Person Interview	§ 3204 State Technology Law Article III	If a telephone or in-person interview will be used with this application, the interview is conducted in the following manner: • Any questions raised during the interview are limited to those questions appearing on an application approved by the Department (i.e., questions over the phone would be no different than those being asked in the application); • The applicant must be provided with a written copy and will have an opportunity to review and make corrections to those statements that were attributed to him/her in the interview; • Any information obtained in the interview that will be used in the underwriting process will be reduced to writing, signed by the applicant and attached to the policy in compliance with Insurance Law § 3204; If an electronic signature is used, it must comply with the Electronic Signatures and Records Act (State Technology Law Article III); and • If a telephonic application is being used, please provide a description of the procedure for taking a telephonic application. Any scripts used in the telephone interview must be filed for reference.	
Written Informed Consent for HIV Testing	§ 2611 Public Health Law § 2782 Circular Letter 3 (1989) Circular Letter 5 (1997)	No insurer or its designee shall request or require an applicant for insurance coverage to be the subject of an HIV related test without receiving the written informed consent of such individual prior to such testing and without providing general information about AIDS and the transmission of HIV infection. Written informed consent to an HIV related test shall consist of a written authorization that is dated and includes at least the following: • a general description of the test; • a statement of the purpose of the test; • a statement that a positive test result is an indication that the individual may develop AIDS and may wish to consider further independent testing; • a statement that the individual may identify on the authorization form the person to whom the specific test results may be disclosed in the event of an adverse underwriting decision, which	

		person may be the individual or a physician or other designee at the discretion of the individual proposed for insurance; • the Department of Health's statewide toll-free telephone number that may be called for further information about AIDS, the meaning of HIV related test results, and the availability and location of HIV related counseling services; and • the signature of the applicant for insurance, or if such individual lacks capacity to consent, the signature of such other person authorized to consent for such individual. *Note: In addition to compliance with the written informed consent under Insurance Law § 2611, the insurer has obligations under Public Health Law § 2782 regarding written informed consent, authorization and disclosure of confidential information regarding HIV testing.*	
Underlying Health Coverage	11 NYCRR 52.15(b)(13)	Application policy forms to be completed by a prospective insured should include the following acknowledgment: I ACKNOWLEDGE THAT I HAVE MAJOR MEDICAL INSURANCE OR SIMILAR COMPREHENSIVE HEALTH INSURANCE COVERAGE. ❑ Yes ❑ No	
CONDITIONAL RECEIPT/INTERIM INSURANCE AGREEMENT FORM			
Advance Premium	11 NYCRR 52.53	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). See product outline for brief summary of requirements.	
POLICY FORM	§3102, §3105, §3201, §3204, §3216 & 11 NYCRR Part 52 (Reg. 62)		Form/Page/Para Reference
COVER PAGE			
Label	11 NYCRR 52.15	Policy is labeled as "Specified Disease Coverage" within the definition of §52.15.	
Insurer Name/Licensee		The licensed New York insurer's name and full address appears prominently on the front or back cover.	
Disclosure/Limited Policy Statement	11 NYCRR 52.15(b)(9)	The cover page contains the statement required by §52.15(b)(9).	
Medicare Notice	11 NYCRR 52.18(a)(7) 11 NYCRR 52.66	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 the cover page of the policy <u>or</u> the first page of the disclosure statement required by §52.66.	
Signature of Company Officer		The signature of company officer(s) appears prominently on the form (such as on the cover).	
DEFINITIONS			
Hospital	11 NYCRR 52.2(m)	"Hospital" means a short-term, acute, general hospital, that: • is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons; • has organized departments of medicine and major surgery; • has a requirement that every patient must be under the care of a physician or dentist; • provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);	

		• if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 USC § 1395x(k); • is duly licensed by the agency responsible for licensing such hospitals; and is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitory care.	
Mental Disorders	§3201(c)(3), §3217(b), §4224(b)(2) 11 NYCRR 52.1(c) 11 NYCRR 52.1(d) 11 NYCRR 52.16(c)(2)	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), and 52.16(c)(2).	
Physician or Health Care Professional	§ 3201(c)(3) § 3217(b) 11 NYCRR 52.1(c) 11 NYCRR 52.1(d) 11 NYCRR 52.911 NYCRR 52.15	The policy form may define a licensed health care professional as an individual acting within the scope of his or her license that typically diagnoses or treats the insured's condition. If used, the policy form should define a "physician" as a licensed health care professional who diagnoses, treats, operates, or prescribes for any human disease, pain, injury, deformity, or physical condition. A licensed physician has completed a program of medical education and received the doctor of medicine (M.D.), doctor of osteopathic medicine (D.O.), or equivalent degree *Note: Policy forms should not unduly limit the insured's access to benefits by requiring that the insured seek care from a physician (meaning an MD or DO) when other licensed health care professionals may diagnose or treat the insured within the scope of their practice.*	
Pre-existing Condition	11 NYCRR 52.15(b)(6)	The definition of "Pre-existing Condition" complies with §52.15(b)(6). The only permissible preexisting condition exclusions are those that exclude coverage for no more than six months after the effective date of coverage under the certificate, for a condition for which medical advice was given or treatment was recommended by, or received, from a licensed health care professional within the six mots before the effective date of coverage.	
Specified Disease Coverage	11 NYCRR 52.15(a)	The definition of "Specified Disease Coverage" complies with § 52.15(a) and (b). 1. Only specifically named diseases may be covered; 2. All covered diseases must be life-threatening in nature and could cause an insured person to incur substantial out of pocket expenses upon diagnosis; and 3. All forms of a specified disease must be covered.	
FORM PROVISIONS			
Assignment	§3201(c)(3), §3216(d)(1)(L), §3217(b) 11 NYCRR 52.15	If the form contains an assignment provision, it complies with §§3201(c)(3), 3216(d)(1)(L), 3217(b), and 52.15.	
Adopted Children and Step-Children	11 NYCRR 52.18(e)(2) 11 NYCRR 52.18(e)(3)	If dependent coverage is selected by the policyholder, the policy form provides that adopted children and stepchildren dependent upon the insured are eligible for coverage on the same basis as natural children. Further, a family policy covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child is eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	
Dependents	§4235(f), § 3221(a)(7)	If dependent coverage is selected by the policyholder, the policy form provides coverage of dependents, and states the age restrictions for the insurance provided.	

Domestic Partners	§ 4235(f) OGC Opinion No. 01-09-11 OGC Opinion No. 01-11-23	The policy form may provide coverage for domestic partners, but such coverage is not required. In order to qualify as domestic partners, the insured must demonstrate proof of mutual economic interdependence evidenced as follows: 1. Registration as a domestic partnership in jurisdictions that have such registration; or 2. If no registration is available, then: a. An alternate affidavit of domestic partnership is required. The affidavit must be notarized and must contain the following: i. The partners are both 18 years of age or older and are mentally competent to consent to contract; ii. The partners are not related by blood in a manner that would bar marriage under laws of the State of New York; iii. The partners have been living together on a continuous basis prior to the date of the application; iv. Neither individual has been registered as a member of another domestic partnership for at least the last six (6) months; b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and c. Evidence of two or more of the following or substantially similar items: joint bank account, joint credit card, joint charge card, joint obligation on a loan, joint ownership in residence, joint ownership of real estate other than residence, joint ownership of vehicle, joint ownership of major items of personal property, listing of both partners on a lease of the shared residence, or other item(s) of proof sufficient to establish economic interdependency.	
New Employees	§ 3221(a)(3)	New employees or members of the class must be added to the class for which they are eligible.	
Newborn Infants	§ 4235(f)(2)	If dependent coverage is selected by the policyholder, the policy form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to Domestic Relations Law § 115-c within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. *Note: In the case of individual or two-person coverage, the insurer must permit the insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of birth to make coverage effective from the moment of birth.*	
Spouse	§ 4235(f) Circular Letter No. 27 (2008)	If dependent coverage is selected by the policyholder, the policy provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes the recognition of marriages between same-sex partners legally performed in New York and other jurisdictions.	
Unmarried Disabled Children	§ 4235(f)(1)(A)(ii)	If dependent coverage is selected by the policyholder, the policy provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. *Note: Such coverage shall not terminate while the policy remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured*	

		has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.	
Unmarried Students on Medical Leave of Absence	§ 3237	If the policy provides coverage for dependent children who are full-time students to a higher age than other dependent children, then coverage shall continue when such dependent takes a medical leave of absence from school due to illness for a period of 12 months from the last day of attendance at school, provided, however, that coverage of a dependent student is not required beyond the age at which coverage would otherwise terminate. To qualify for such coverage, the insurer may require that the medical necessity of the leave be certified to by the student's attending physician who is licensed to practice in the state of New York.	
Military Suspension	§3221(n) §3221(o) 11 NYCRR 52.18(e)(3) Circular Letter No. 7 (2003)	Suspension provision for insureds called to active duty in the armed forces complies with §§3221(n), 3221(o), and 11 NYCRR 52.18(e)(3).	
Refund of Premium upon Death	§3228	This form provides for a refund of premium upon death per §3228.	
Waiver of Premium	§3201(c)(3) §3217(b) 11 NYCRR 52.1(c) 11 NYCRR 52.1(d) 11 NYCRR 52.15 11 NYCRR 52.16(b)	If the form contains a provision for waiver of premium during a period of sickness, it complies with §§3201(c)(3), 3217(b), 52.1(c), 52.1(d), 52.15, and 52.16(b).	
SPECIFIED DISEASE REQUIREMENTS			
Benefit Offset	11 NYCRR 52.15(b)(4)	Benefits for specified disease coverage will be paid regardless of other coverage, except for any policy provision regarding other insurance with the insurer providing specified disease coverage. *Note: §3216(d)(2)(C) of the Insurance Law sets forth the optional standard provision for "Other Insurance in This Insurer."*	
Covered Benefits	11 NYCRR 52.15 §3201(c)(3) §3217(b)	a. The form contains ONLY benefits related to specified disease coverage as defined in §52.15(a). It does not contain any benefits unrelated to specified disease coverage (i.e., categories defined in Regulation 62 other than §52.15). b. All forms of the specified disease or diseases are covered. §52.15(b)(1). c. The Department will not approve a Specified Disease policy or certificate which contains coverage for a disease or diseases that are considered Rare Diseases. The Department considers any disease that is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network or affects fewer than two hundred thousand residents a per year, to be a Rare Disease. Due to the very low occurrences of these diseases, the Department considers coverage for such diseases in Specified Disease policies to be misleading, deceptive, unlikely to provide substantial economic value to policyholders, and contrary to the public policy of the state and, as such, violative of Insurance Law Sections §§ 3201(c)(3) and 3217(b). d. The Department will not approve a Specified Disease policy or certificate which contains coverage for a disease or diseases for which there is a vaccine available. The Department considered such benefits unlikely to unlikely to provide substantial economic value to	

		policyholders, and contrary to the public policy of the state and, as such, violative of Insurance Law Sections §§ 3201(c)(3) and 3217(b).	
Diagnosis	11 NYCRR 52.15(b)	a. If the filing uses the term "first diagnosis," "first treatment," "first manifested," or a similar term, such term(s) will be administered in compliance with §52.15(b)(6). b. If the form conditions benefit payment on pathological diagnosis of a covered disease: • The form provides that, if such a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead. • The form provides that <u>any</u> type of medically appropriate diagnosis will be accepted. §52.15(b)(2).	
Overinsurance	11 NYCRR 52.15(b)(8)	This filing contains the insurer's overinsurance rules. Overinsurance exists when: • An insured has more than one specified disease policy for the <u>same</u> specified disease, regardless of the insurer, <u>or</u> • A policy is issued to any person that results in that person becoming covered by <u>8 or more</u> specified diseases. *Note: Maximum number of specified diseases for which an individual may be covered is 7, regardless of the number of insurers.*	
Reduction in Benefits	11 NYCRR 52.15(b)(16)	The form does <u>not</u> contain a reduction in specified disease benefits (e.g., when certain events occur or ages are reached).	
Underlying Coverage	11 NYCRR 52.5 11 NYCRR 52.6 11 NYCRR 52.7 11 NYCRR 52.15(b)(12)	Specified disease coverage will <u>only</u> be issued to persons covered by either <u>at least</u> major medical insurance (defined in §52.7) or <u>at least</u> basic hospital insurance and basic medical insurance (defined in §§52.5 and 52.6). §52.15(b)(12) (i.e., comprehensive hospital/medical/surgical coverage). Within 30 days after policy delivery, the insurer will ask the insured person(s) in a written request whether the insured person(s) has in force <u>at least</u> major medical insurance or <u>at least</u> basic hospital insurance and basic medical insurance on the effective date of the specified disease coverage. If an insured responds that the underlying coverage is not in force on the effective date of the specified disease coverage, the policy will be voided from its beginning with a full premium refund. §52.15(b)(14). *Note: <u>Attach an explanation</u> of the method by which the insurer will implement these requirements. See outline for details.*	
INDEMNITY AND NON-RECURRING SPECIFIED DISEASE REQUIREMENTS		*Note: An example of Indemnity and Non-Recurring basis is payment of a lump sum benefit upon diagnosis. (If the form benefits are conditioned on ongoing treatment, use the checklist and outline for Recurring coverage instead.)*	
Benefits Payable	11 NYCRR 52.15(d)	*a.* Benefits will always be payable upon initial and medically appropriate diagnosis of the specified disease covered by the policy subject to the probationary period allowed in §52.15(d)(2). *Note: "Initial" refers to while the policy is in force.* b. The policy clearly specifies the criteria to be satisfied in order to trigger the payment of benefits. §52.15(d)(6).	
Payment Conditions	11 NYCRR 52.15(d)	The policy (and any riders) has been designed as a §52.15(d) non-recurring (lump sum) specified disease policy and is <u>not</u> a §52.15(c) recurring specified disease policy.	
Dollar Benefits	11 NYCRR 52.15(d)(1)	Dollar benefits are offered only in even increments of $1,000 and do not exceed $500,000. If Dollar benefits are <u>less than $1,000</u>, the following requirements must be met:	

		a. The dollar benefit is not less than $250. b. The provision clearly indicates that this lower benefit applies to a clearly identifiable form of a disease with significantly lower treatment costs. c. Attach an opinion statement from a medical professional verifying that this is a clearly identifiable form of the disease with significantly lower treatment costs.	
Maximum Policy Benefit	11 NYCRR 52.15(d)(5)	Benefit amounts payable for any one specified disease are subject to a maximum policy benefit for all specified diseases covered under the policy.	
Payment of Indemnity Amounts May Not Be Paid in More than Two Equal Installments	11 NYCRR 52.15(d)(3)	Specified disease benefits must be paid on diagnosis of a specifically named disease that is covered under the policy. If a policy has a reoccurrence benefit, that benefit may only be paid once and must be paid in an amount equal to the initial diagnosis benefit.	
Probationary Period	11 NYCRR 52.15(d)	If the form contains a probationary period: a. The probationary period is no more than 30 days from the coverage effective date. §§52.15(d)(2), 52.16(d)(1). b. During the probationary period, the insurer may void the policy from its beginning with a full premium refund to the insured for a specified disease diagnosed within the initial 30 days of coverage. §52.15(d)(2) A new probationary period for any one specified disease is not instituted for: a. Any recurrence or spread of the same specified disease, or b. A new primary occurrence of the same specified disease. §52.15(d)(4).	
MANDATORY STANDARD PROVISIONS		*Note: These provisions must be included in each policy. The provision must be no less favorable to the insured than the statutory provision.*	
Arbitration	§ 3221(a)(14)	The policy form cannot provide for mandatory arbitration. An arbitration provision which makes arbitration mandatory conflicts with Insurance Law § 3221(a)(14) since it precludes an insured from bringing an action at law or equity.	
Certificate	§ 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.	
Changes	§ 3221(a)(2)	The policy form 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.	
Claim Forms	§3221(a)(10)	The policy form 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.	
Entire Contract	§ 3204	The policy form, including any endorsements or attached papers (if any), constitutes the entire contract of insurance. No change in the policy will be valid unless it is approved by an executive officer of the insurer and the approval is endorsed on or attached to the policy. No agent or broker has the authority to change the policy or waive any of its provisions. Incorporation by reference is not permitted.	
Premium Payment and Grace Period	§3221(a)(4)	The policy form 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..	
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.	
Certificates	§3221(a)(6)	The insurer must issue a certificate in compliance with §3221(a)(6).	
Eligible Class	§3221(a)(3)	This provision must be included and must be no less favorable to the insured than the statutory provision.	
Indemnity for Loss of Life	§3221(a)(13)	The policy form must provide that indemnity for loss of life is payable in accordance with Insurance Law § 4235(e). According to Insurance Law § 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.	
Misstatement	§ 3221(a)(1)	The policy form 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.	
Renewal	§ 3221(a)(5) 11 NYCRR 52.18(c)	The policy form must specify the conditions under which the insurer may refuse to renew the policy.	
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.	
Payment of Claims	§3221(a)(12)	The policy form must provide that benefits payable under the policy other than for benefits for loss of time will be payable not more than 60 days after receipt of proof of loss.	
Physical Examinations 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.	
Policy Changes	§3221(a)(2)	This provision must be included and must be no less favorable to the insured than the statutory provision.	
Proofs of Loss	§3221(a)(9)	The policy must provide that the insured has a minimum of 120 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.	
Statements of Insured	§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.	
Unilateral Modification	11 NYCRR 52.18(a)(8)	Unilateral modifications by an insurer to an existing policy must be made with at least 30 days prior written notice to the policyholder. Unilateral modification by the insurer may be made only at the time of renewal. A contractual requirement to provide prior written termination requires at least 14 days notice. If the policy requires the policy holder to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to such policy holder no less	

		than 14 days prior to the date by which the policy holder is required to provide notice to terminate coverage.	
Notice of Termination	11 NYCRR 52.18(c)	Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	
OPTIONAL STANDARD PROVISIONS		*These provisions may be included at the insurer's option.*	
Subrogation	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a)	Any subrogation provision must comply with the General Obligations Law that affects an insurer's reimbursement rights. When an insured settles a claim, whether in litigation or otherwise, against one or more other persons for personal injuries, medical, dental, or podiatric malpractice, or wrongful death, it shall be conclusively presumed that the settlement does not include any compensation for the cost of health care services, loss of earnings or other economic loss to the extent those losses or expenses have been or are obligated to be paid or reimbursed by an insurer. By entering into any such settlement, an insured shall not be deemed to have taken an action in derogation of any right of any insurer that paid or is obligated to pay those losses or expenses; nor shall an insured's entry into such settlement constitute a violation of any contract between the insured and such insurer. No insured entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by an insurer and an insurer shall have no lien or right of subrogation or reimbursement against any such settling person or any other party to such a settlement, with respect to those losses or expenses that have been or are obligated to be paid or reimbursed by said insurer.	
Wellness Programs	§3239	Wellness programs are permitted and are defined as programs designed to promote health and prevent disease that may contain rewards and incentives for participation. A wellness program may include but is not limited to: the use of a health risk assessment tool; a smoking cessation program; a weight management program; a stress management program; a worker injury prevention program; a nutrition education program; and a health or fitness incentive program. A wellness program may use rewards and incentives for participation provided that where the group health insurance policy or subscriber contract is required to be community-rated, the rewards and incentives shall not include a discounted premium rate or a rebate or refund of premium. Permissible rewards and incentives include: full or partial reimbursement of the cost of participating in smoking cessation or weight management programs; full or partial reimbursement of the cost of membership in a health club or fitness center; the waiver or reduction of copayments, coinsurance and deductibles for preventive services covered under the group policy or subscriber contract; and monetary rewards in the form of gift cards or gift certificates, so long as the recipient of the reward is encouraged to use the reward for a product or a service that **promotes good health**, such as healthy cook books, over the counter vitamins or exercise equipment. Participation in the wellness program must be available to similarly situated members of the group and must be voluntary on the part of the member. The terms of the wellness program must be set forth in the policy or contract.	
PERMISSIBLE EXCLUSIONS & LIMITATIONS			
Alcoholism and Drug Addiction	11 NYCRR 52.16(c)(2) §3216(d)(2)(K)	If an insurer chooses to place an exclusion or limitation on coverage for treatment arising out alcoholism or drug addiction, it must comply with §§52.16(c)(2) and 3216 (d)(2)(K) as pertinent. The policy form may exclude coverage for alcoholism or drug addiction.	

Cause of Illness, Treatment, or Medical Condition	11 NYCRR 52.16(c)(4) §3216(d)(2)(J)	If an insurer chooses to place an exclusion or limitation on coverage for illness, treatment, or medical condition arising out of the following situations, it must comply with §52.16(c)(4): a. war or act of war (whether declared or undeclared); b. participation in a felony, riot or insurrection; (*Note: For felony participation, see also §3216(d)(2)(J))* c. service in the armed forces or units auxiliary thereto; d. suicide, attempted suicide, or intentionally self-inflicted injury (*Note: No distinction is made for sane or insane*); or aviation (other than as a fare paying passenger on a scheduled or charter flight operated by a scheduled airline).	
Chiropractic Care	11 NYCRR 52.16(c)(7)	The policy form may exclude care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. Convalescent, Custodial Care and Transportation 11 NYCRR 52.16(c)(11).	
Cosmetic Surgery	11 NYCRR 52.16(c)(5)	The policy form may exclude coverage for cosmetic surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. *Note: All exclusions for cosmetic surgery must be based on medical necessity, with the insured receiving all utilization review and external appeal rights under Article 49*	
Convalescent, Custodial Care and Transportation	11 NYCRR 52.16(c)(11) 11 NYCRR 52.25(a)(1)11 NYCRR 52.16(c)(11)	The policy form may exclude coverage for rest cures, custodial care, and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities.	
Dental	11 NYCRR 52.16(c)(9)	The policy form may exclude coverage of dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and for dental care or treatment necessary due to congenital disease or anomaly.	
Extra-Hazardous Activities	11 NYCRR 52.16(e) 11 NYCRR 52.2(i)	The policy form may exclude coverage for extra-hazardous activities in accordance with 11 NYCRR 52.16(e). The insurer must seek a signed waiver of coverage from the prospective insured or, in the alternative, place the extra-hazardous activity exclusionary language on the cover page of the policy and certificate. For additional information, see the "Extra-hazardous Activities" section under "Application Forms." *Note: The Department has determined that the following activities are not "extra-hazardous" as defined by 11 NYCRR 52.2(i) and may not be excluded under the policy: base jumping, bungee jumping, caving, parasailing, parkour, mountain or rock climbing, or scuba diving. This list is not meant to be exhaustive.*	
Eyeglasses, Hearing Aids, and Exams	11 NYCRR 52.16(c)(10)	The policy form may exclude coverage for eyeglasses, hearing aids and examination for the prescription or fitting thereof. If an insurer chooses to place an exclusion or limitation on eyeglasses, hearing aids, and exams, it must comply with §52.16(c)(10).	

Foot Care	11 NYCRR 52.16(c)(6)	The policy form may exclude coverage for foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.	
Government Facility	11 NYCRR 52.16(c)(8)	The policy form may exclude coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise provided by law.	
Intoxicants and Narcotics	§ 3221(c) § 3216(d)(2)(K)	The policy form may exclude coverage for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.	
Immediate Family	11 NYCRR 52.16(c)(8)	The policy form may exclude coverage for services performed by a member of the insured's immediate family. Immediate family has the same meaning as defined in 42 CFR § 411.351: husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.	
Illegal Occupation	§ 3221(c) § 3216(d)(2)(J)	The policy form may exclude losses to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.	
Mental or Emotional Disorders	11 NYCRR 52.16(c)(2)	The policy may exclude coverage of mental or emotional disorders.	
Coverage outside of the United States, Canada or Mexico	11 NYCRR 52.16(c)(12)	The policy form may exclude for coverage while the insured is outside of the United States, its possessions, Canada or Mexico. The company must provide coverage for a subsequent diagnosis of the specifically named disease or diseases with the United States, its possessions, Canada or Mexico.	
Pre-Existing Conditions	11 NYCRR 52.15(b)(6)	If an insurer chooses to place a pre-existing condition limitation in the coverage, it must comply with §52.15(b)(6). *Note: This is the <u>only</u> permissible pre-existing condition limit allowed for specified disease coverage.*	
Pregnancy	11 NYCRR 52.16(c)(3)	The policy form may exclude coverage for pregnancy except for complications of pregnancy.	
Transportation	11 NYCRR 52.16(c)(11)	If an insurer chooses to place an exclusion or limitation on transportation, it must comply with §52.16(c)(11).	
Workers' Compensation	11 NYCRR 52.16(c)(8)	If an insurer chooses to place an exclusion or limitation on services for which benefits are <u>provided</u> by any state or federal workers' compensation, employer's liability or occupational disease law, it must comply with §52.16(c)(8). Note: The term "provided" is permitted, not "payable" or "reimbursable."	
RATE-RELATED INFORMATION			
Loss Ratio	11 NYCRR 52.45(j)(2)(iv))	The minimum loss ratio for the policy complies with 11 NYCRR52.45(j)(2)(iv) .	
Sex Basis for Rates	11 NYCRR 52.41	This form is rated on the following basis: **(select only one)** ☐ Unisex basis, <u>or</u> ☐ Sex-distinct basis and will <u>not</u> be issued in any employer/employee situation subject to the *Norris* decision and/or Title VII of the Civil Rights Act of 1964.	
Benefit Selections	11 NYCRR 52.31(f) §3204 (a)(1)	The schedule page sets forth optional choices of insured regarding certain benefits and/or riders selected by the insured.	
Effective Date and Renewal Dates	11 NYCRR 52.31(f)	The schedule page includes spaces for effective date of insurance, renewal dates and renewal terms.	
Hypothetical Data	11 NYCRR 52.31(f)	The schedule page is completed with hypothetical data.	
Name of Insured	11 NYCRR 52.31(f)	The schedule page includes space for the insured's name.	

Premium Summary	11 NYCRR 52.31(f)	The schedule page contains premium summary amounts and provisions dealing with insured participation status in surplus or dividends.	
Varying Elements	11 NYCRR 52.15(d)(2) 11 NYCRR 52.31(f) §3204 (a)	The schedule page sets forth amounts payable for certain specified diseases, probationary period time provisions complying with §52.15(d)(2), and similar varying elements of the policy selected by the insured.	
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. • No advertisement of the policy will imply coverage beyond the terms of the policy. Synonymous terms will not be used to refer to any disease so as to imply broader coverage than is the fact. 11 NYCRR 52.12(b)(10). • 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 Letters 3 (1989) and 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 will not refuse to issue coverage, cancel coverage, or decline to renew coverage because of the sex or marital status of the applicant or policyholder. §2607 of the Insurance Law.	
NEW PRODUCTS – RATE REQUIREMENTS	11 NYCRR 52.40(e)(1)	*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.* • *(For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below instead.)*	Form/Page/Para Reference
ACTUARIAL MEMORANDUM	11 NYCRR 52.40(a)(1)	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	11 NYCRR 52.40(e)(2)(ii)(b) 11 NYCRR 52.15(a) 11 NYCRR 52.15(b) 11 NYCRR 52.15(d)	a. Specific formulas and assumptions used in calculating rates b. Expected claim costs c. Actuarial justification for the use of claim costs and other assumptions d. Description of marketing methods e. Justification of gross premium differentials based on sex f. If occupational classifications exist, provide a description and actuarial justification c. Non-claim expense components as a percentage of gross premium	
Loss Ratios	11 NYCRR 52.40(e)(2)(ii)(b)	Expected loss ratios by duration and in the aggregate – with actuarial justification	

	11 NYCRR 52.45(j)(2)(iv)		
Actuarial Certification	11 NYCRR 52.40(a)(1) 11 NYCRR Part 94	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.	
Expected Loss Ratio Certification	11 NYCRR 52.45(j)(2)(iv)	The expected loss ratio is: ________ %	
RATE MANUAL	11 NYCRR 52.40(e)(2)(i)	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 ratios	
EXISTING PRODUCTS – RATE REQUIREMENTS	11 NYCRR 52.40(e)(1)	*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.* ***(For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.)***	Form/Page/Para Reference
ACTUARIAL MEMORANDUM	11 NYCRR 52.40(a)(1)	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	11 NYCRR 52.40(e)(2)(ii)(b) 11 NYCRR 52.15(a) 11 NYCRR 52.15(b) 11 NYCRR 52.15(d)	a. Description of benefits b. History of previous New York rate revisions. If nationwide experience is included per item (e) below, provide history of previous non-New York rate revisions as well. c. First and last years of issue d. Actual and expected loss ratios by duration e. Complete New York experience since inception. If New York experience is not credible, provide nationwide experience as well. (i) Yearly and in total (ii) All items except reserves accumulated with interest (accumulated from midpoint of calendar year to most recent Dec. 31) (iii) As in (i), but with premiums adjusted to the current New York rate schedule. Describe the basis for all reserves. f. Derivation of the proposed rate revision in detail, including demonstrations that: (i) The expected future loss ratio and expected lifetime loss ratio are at least as large as the disclosure loss ratio, and	

		(ii) The expected future loss ratio is at least as large as the applicable minimum loss ratio per 11 NYCRR 52.45(j)(2)(iv). g. 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	11 NYCRR 52.40(a)(1) 11 NYCRR Part 94	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.	
Expected Loss Ratio	11 NYCRR 52.45(j)(2)(iv)	The expected loss ratio is: ______ %	
REVISED RATE MANUAL PAGES	11 NYCRR 52.40(e)(2)(i)	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	