TITLE 760 DEPARTMENT OF INSURANCE

ARTICLE 1. GENERAL PROVISIONS

Rule 1. Automobile Liability Insurance–Policy Form

760 IAC 1-1-1 Disclaimer of personal injury or property damage coverage

Authority: IC 27-1-3-7
Affected: IC 27-1-13-7

Sec. 1. Whenever any insurance company authorized to do business in the State of Indiana issues an automobile insurance policy providing collision or material damage coverage only and which does not provide liability coverage for personal injury or property damage, the policy or the certificate given in lieu thereof shall contain the following notation upon its face or filing back:

"THIS POLICY (CERTIFICATE) DOES NOT PROVIDE LIABILITY INSURANCE FOR BODILY INJURY OR PROPERTY DAMAGE."

Such notice shall appear in not less than 10 point type. It may be printed or may be made by rubber stamp impression; provided, however, that deviation from the form prescribed herein may be permitted upon the approval of the Department of Insurance of Indiana. *(Department of Insurance; Reg 1; filed Dec 24, 1952, 11:20 am: Rules and Regs. 1953, p. 157; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

Rule 2. Fire Insurance-Policy Form (Repealed)

(Repealed by Department of Insurance; filed Jan 16, 1979, 4:11 pm: 2 IR 312)

Rule 3. Domestic Stock Insurance Companies–Organization, Promotion and Capital Enlargement

760 IAC 1-3-1 Authority to promulgate rule

Authority: IC 27-1-3-7
Affected: IC 27-1-1-1; IC 27-1-2-1; IC 27-1-3; IC 27-1-6-17; IC 27-1-6-18; IC 27-1-20-32

Sec. 1. AUTHORITY FOR REGULATION. Pursuant to the mandate of Section II *[IC 27-1-3-4]* of the Indiana Insurance Law reading:

"Every insurance company to which this act *[IC 27-1-2-1 – IC 27-1-20-32]* is applicable shall conduct and transact its business in a safe and prudent manner; shall maintain such company in a safe and solvent condition; and shall establish and maintain safe and sound methods for the conduct of such insurance company and its business and prudential affairs."

and pursuant to authority reposed in The Department of Insurance under Section 1 *[IC 27-1-1-1]* of the Acts 1945, ch. 351 and Sections 14, 15, 17, 26, 76 and 77 *[IC 27-1-3-7, IC 27-1-3-8, IC 27-1-3-10, IC 27-1-3-19, IC 27-1-6-17 and IC 27-1-6-18]* of the Indiana Insurance Law, this Regulation, No. 1956-1, is hereby adopted. *(Department of Insurance; Reg 1956-1,I; filed Jan 4, 1957: Rules and Regs. 1958, p. 124; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-3-2 Incorporation and promotion of new insurance companies; permits

Authority: IC 27-1-3-7
Affected: IC 27-1-6-11; IC 27-1-6-19

Sec. 2. INCORPORATION AND PROMOTION OF NEW INSURANCE COMPANIES. (1) In addition to the requirements and conditions expressly prescribed in the Indiana Insurance Law, relative to the organization and promotion of new stock insurance companies, the Commissioner will require that the incorporators of a new company submit to him in duplicate, authenticated copies of the following items, to the extent they are involved or used in the incorporation or promotion procedures, namely:

(a) Any and all contracts, letters, memoranda, plans, resolutions, or other documents (exclusive of those expressly required to be filed under any section of the Indiana Insurance Law) pertaining in any way to the organization or promotion of the subject company, or to the rights and duties of the organizers inter se or in relation to the company, or pertaining to the gain or profits the organizers contemplate receiving from the corporate venture.

(b) Stock subscription agreement.

(c) Note or other promissory instrument or instruments for use incident to the subscription or payment for stock in the subject company.

(d) Prospectus and any other promotional literature for use in selling stock of the subject company.

(e) Registration certificate or certificates issued by the Securities Commission of Indiana, relative to the stock of the subject company and its sale through dealers.

(f) The names and addresses of all individuals, partnerships, and corporations which by contract have been authorized to solicit stock subscription and the agreement or agreements under which such person or persons or organizations will operate and be compensated.

(g) The number of shares of stock to be offered in the first issue and the price at which such stock will be offered and sold.

(h) An estimate of the maximum expense of issuing and selling capital stock of the first issue and in accomplishing all other organizational procedures.

(i) An agreement, on a form to be prepared by the Commissioner, executed by all the incorporators, obligating the incorporators to submit promptly any items of information specifically or generally described in the foregoing enumeration which come into existence during the period of organization or during the period of one year subsequent to the organization meeting provided for under Section 78 *[IC 27-1-6-19]* of the Indiana Insurance Law.

(2) The Commissioner, on the basis of the items of information enumerated above, together with other information available to him in the files of the Department of Insurance and the Indiana Securities Commission, will issue or decline to issue to the Company a permit under Section 71 *[IC 27-1-6-11]* of the Indiana Insurance Law, relating to the completion of the Company's incorporation.

(3) The Commissioner may, in the manner provided by law, revoke the permit considered in the preceding paragraph, or any other permit or certificate provided for in the Indiana Insurance Law having to do with the organization or operation of a new insurance company, if he finds that the organizers are not fulfilling the standards or requirements prescribed in the Sections of law referred to in Article I *[760 IAC 1-3-1]* above, or if the agreement referred to in II 1 (i) *[subsection (1)(i) of this section]* is not fulfilled. *(Department of Insurance; Reg 1956-1,II; filed Jan 4, 1957: Rules and Regs. 1958, p. 124; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-3-3 Second or subsequent stock issues; approval

Authority: IC 27-1-3-7
Affected: IC 27-1-6-4; IC 27-1-6-11

Sec. 3. SECOND OR SUBSEQUENT ISSUES OF STOCK BY AN INSURANCE COMPANY HERETOFORE OR HEREAFTER ORGANIZED. (1) A second or subsequent issue of stock by a stock insurance company heretofore or hereafter organized (stock issued as a dividend excepted) shall be cleared with the Commissioner through the identical process described in paragraph II *[760 IAC 1-3-2]* above in relation to a company in the process of incorporation, except that the Commissioner will not require the submission of information already in his file on certification by the company that a duplication would result were a stated requirement fulfilled.

(2) With respect to a second or subsequent issue of stock by a company which has been in existence for a period less than six years, the information and agreements described in subparagraphs (a) and (b) below shall be submitted to the Commissioner in addition to the data required in paragraph 1 above, namely:

(a) A statement showing parallel columns the names and addresses of the directors, officers and the ten largest stockholders of the company and, separately, of any related or subsidiary company, and the number of shares of the company or companies respectively owned by each of such persons.

(b) An agreement on the part of each director, officer or stockholder owning, in the case of the latter, 10% or more of the respective stocks described in (a) above, to the effect that such director, officer or stockholder will not, during the period the stock is being offered and for the period of six months following the termination of the offering period, sell or offer for sale any stock he may own or which he controls in such company or companies at a price higher than the price at which was acquired by him or by any other person for his use and benefit. In applying this subparagraph to any director, officer or stockholder, he shall be regarded as owning stock in which he has a beneficial interest or which, regardless of discernible beneficial interest, is registered in the name of his wife, child, father or mother, or any or all of same.

(3) The Commissioner's approval of a second or subsequent issue of stock will not be granted if it appears from all the facts

and circumstances presented to the Commissioner that the motivation for such issue is the personal advantage of directors, officers or stockholders as distinguished from a need of the company for additional capital. *(Department of Insurance; Reg 1956-1,III; filed Jan 4, 1957: Rules and Regs. 1958, p. 126; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-3-4 Cooperation with securities commissioner

Authority: IC 27-1-3-7
Affected: IC 23-2-1-15; IC 27-1-6-11

Sec. 4. COLLABORATION WITH INDIANA SECURITIES COMMISSIONER. The Commissioner in administering the regulations propounded in paragraphs II and III *[760 IAC 1-3-2 and 760 IAC 1-3-3]* above will be mindful of the requirements and administrative procedures under the Indiana Securities Law, and, accordingly will seek to minimize duplications of procedures and information wherever possible, and he may consult with the Securities Commissioner relative to decisions which both offices are respectively required to make pursuant to law or this regulation *[760 IAC 1-3]*. *(Department of Insurance; Reg 1956-1,IV; filed Jan 4, 1957: Rules and Regs. 1958, p. 126; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-3-5 New companies; enlargement of established companies

Authority: IC 27-1-3-7
Affected: IC 27-1-3-4; IC 27-1-6-18

Sec. 5. RULES AND PRINCIPLES. The Commissioner of Insurance, in considering questions relating to the organization of a new stock company, or relating to the enlargement of the capital of an established stock insurance company, will be guided by the following concepts, rules and principles, among others:

(1) The organization and promotion of new insurance companies on a sound basis is to be commended and encouraged.

(2) The business of insurance, because of its direct and vital effects upon stockholders, policyholders and the economy generally, is vital in the public interest and welfare.

(3) The organization and capitalization of insurance companies should be carefully scrutinized in keeping with the concepts, rules and principles herein enunciated.

(4) Organization and promotion expenses, inclusive of commissions paid for sale of stock, but exclusive of legal expenses and statutory organization fees and charges, should not under any circumstances exceed ten percent of the sale price of stock actually sold. In the instance of the organization of a new company, the funds derived from the sale of stock, in excess of expenses as limited herein, must be placed in trust or escrow until such funds can be delivered to the company upon, or subsequent to, the issuance of its certificate of authority under Section 77 *[IC 27-1-6-18]* of the Indiana Insurance Law.

(5) In the event a new stock issue is approved by the Department within the period of five years immediately subsequent to the date of the company's original license to do an insurance business, the sale price for the new issue shall be subject to the Commissioner's approval and may not exceed two hundred percent of the lowest price at which any shares were previously issued, except that a higher price may be fixed for a new issue, if in the opinion of the Commissioner the condition of the company justifies, taking into consideration the company's financial condition, business in force and facts relating to the stock's history, such as stock splits, stock dividends, changes in par value, and the like.

(6) The sale price of stock should be payable either in cash or by an interest-bearing promissory note payable within ninety days. In event a promissory note is given in payment for stock, there should be no tie-in with or inter-dependence between the note obligation and the purchase of insurance or with projected dividends from such insurance.

(7) With respect to stock companies hereafter organized, any arrangement, device, plan or scheme, however contrived or formulated, having as its end or purpose a diversion, either directly or indirectly, of the company's funds, other than in payment of legitimate dividends or costs of doing business, to any officer(s), director(s), organizer(s), or promoter(s) of the company, or to any association, corporation, partnership or trust owned or controlled by any officer(s), director(s), organizer(s) or promoter(s) of the company, is hereby declared in violation of the statutory mandate that “every insurance company conduct and transact its business in a safe and prudent manner” and “maintain safe and sound business methods.” *(Department of Insurance; Reg 1956-1,V; filed Jan 4, 1957: Rules and Regs. 1958, p. 127; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-3-6 Consistency of rule with statute
Authority: IC 27-1-3-7
Affected: IC 27-1-6-11

Sec. 6. This regulation *[760 IAC 1-3]*, representing as it does a projection of the workings of the insurance law in a specific area, shall not be regarded either as a contraction or enlargement of the insurance law, but rather, as an administrative application or interpretation of such law. *(Department of Insurance; Reg 1956-1,VI; filed Jan 4, 1957: Rules and Regs. 1958, p. 128; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-3-7 Applicability of rule
Authority: IC 27-1-3-7
Affected: IC 27-1-6-11

Sec. 7. This regulation *[760 IAC 1-3]* is intended to apply only to actual offering and sale of stock to the public. It does not apply to changes in corporate structure, amendments to articles of incorporation, merger, consolidation or other corporate changes which do not involve the public offering of stock; nor is it intended to cover situations which are exempt from registration under provisions of the Indiana Securities Law or regulations of the Indiana Securities Commission. *(Department of Insurance; Reg 1956-1,VII; filed Jan 4, 1957: Rules and Regs. 1958, p. 128; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-3-8 Effective date; discretionary transitional application of rule
Authority: IC 27-1-3-7
Affected: IC 27-1-6-11

Sec. 8. This regulation *[760 IAC 1-3]* shall be effective from the date of its formal publication by the Commissioner of Insurance. To the end that hardships may be minimized, the Commissioner will exercise his discretion in ameliorating the operation of the various provisions of the regulation in relation to companies in the process of organization at the time of its adoption. *(Department of Insurance; Reg 1956-1,VIII; filed Jan 4, 1957: Rules and Regs. 1958, p. 128; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

Rule 4. Multiple Line Packages–Filing of Rates, Rules and Coverages (Repealed)
(Repealed by Department of Insurance; filed Jul 18, 1996, 9:00 a.m.: 19 IR 3466)

Rule 5. Credit Life, Accident and Health Insurance–Premium Rates and Refunds (Repealed)
(Repealed by Department of Insurance; filed Sep 9, 2002, 3:00 p.m.: 26 IR 26)

Rule 5.1. Credit Life Insurance; Credit Accident and Health Insurance

760 IAC 1-5.1-1 Purpose and authority
Authority: IC 27-1-3-7; IC 27-8-4-12
Affected: IC 24-4.5-4-102

Sec. 1. The purpose of this rule is to protect the interests of debtors and the public in this state by providing a system of rate, policy form, and operating standards for the regulation of consumer credit insurance. *(Department of Insurance; 760 IAC 1-5.1-1; filed Sep 9, 2002, 3:00 p.m.: 26 IR 19, eff Jan 1, 2003)*

760 IAC 1-5.1-2 Definitions
Authority: IC 27-1-3-7; IC 27-8-4-12
Affected: IC 24-4.5-4-102; IC 27-1-23-1

Sec. 2. (a) The following definitions apply throughout this rule:

(1) "Affiliate" has the meaning set forth in IC 27-1-23-1.
(2) "Closed-end credit" means a credit transaction that does not meet the definition of open-end credit.
(3) "Compensation" means:
(A) commissions;
(B) dividends;
(C) retrospective rate credits;
(D) service fees;
(E) expense allowances or reimbursements;
(F) gifts;
(G) furnishing of equipment, facilities, goods, or services; or
(H) any other form of remuneration resulting directly from the sale of consumer credit insurance.
(4) "Consumer credit insurance" is a general term used to refer to any or all of credit life insurance and credit accident and health insurance.
(5) "Control" has the meaning set forth in IC 27-1-23-1.
(6) "Evidence of individual insurability" means a statement furnished by the debtor, as a condition of insurance becoming effective, that relates specifically to the health status or to the health or medical history of the debtor.
(7) "Gross debt" means the sum of the remaining payments owed to the creditor by the debtor.
(8) "Identifiable insurance charge" means a charge for a type of consumer credit insurance that is made to debtors having such insurance and not made to debtors not having such insurance; it includes a charge for insurance that is disclosed in the credit or other instrument furnished to the debtor that sets out the financial elements of the credit transaction and any difference in the finance, interest, service, or other similar charge made to debtors who are in like circumstances except for the insured or noninsured status of the debtor.
(9) "Loss ratio" means incurred claims divided by the sum of earned premiums and imputed interest earned on unearned premiums.
(10) "Net debt" means the amount necessary to liquidate the remaining debt in a single lump sum payment, excluding all unearned interest and other unearned finance charges.
(11) "Open-end credit" means credit extended by a creditor under an agreement in which the:
(A) creditor reasonably contemplates repeated transactions;
(B) creditor imposes a finance charge from time to time on an outstanding unpaid balance; and
(C) amount of credit that may be extended to the debtor during the term of the agreement (up to any limit set by the creditor) is generally made available to the extent that any outstanding balance is repaid.
(12) "Person" has the meaning set forth in IC 27-1-23-1.
(13) "Preexisting condition" means any condition for which the insured debtor received medical advice, consultation, or treatment within six (6) months before the effective date of the coverage and from which the insured debtor becomes disabled within six (6) months after the effective date of this coverage.
(b) The following definitions apply throughout section 10 of this rule:
(1) "Experience" means earned premiums and incurred losses during the experience period.
(2) "Experience period" means the most recent period of time for which earned premiums and incurred losses are reported, but not for a period longer than three (3) full years.
(3) "Incurred losses" means total claims paid during the experience period, adjusted for the change in claim reserve.

(Department of Insurance; 760 IAC 1-5.1-2; filed Sep 9, 2002, 3:00 p.m.: 26 IR 20, eff Jan 1, 2003)

760 IAC 1-5.1-3 Rights and treatment of debtors

Authority: IC 27-1-3-7; IC 27-8-4-12
Affected: IC 24-4.5-4-102; IC 27-1-12-37; IC 27-8-4-4

Sec. 3. (a) If a creditor makes available to the debtors more than one (1) plan of consumer credit insurance, every debtor must be informed of each plan for which the debtor is eligible and of the premium or insurance charge for each.

(b) When a creditor requires insurance as additional security for a debt, the creditor shall inform the debtor that the debtor has the option of procuring alternative coverage. The debtor shall be informed by the creditor of the right to provide alternative

coverage before the transaction is completed.

(c) The following applies to the termination of a group consumer credit insurance policy:

(1) If a debtor is covered by a group consumer credit insurance policy providing for the payment of single premiums to the insurer, or any other premium payment method that prepays coverage beyond one (1) month, then provision shall be made by the insurer that in the event of termination of the policy for any reason, insurance coverage with respect to any debtor insured under the policy shall be continued for the entire period for which the premium has been paid.

(2) If a debtor is covered by a group consumer credit insurance policy providing for the payment of premiums to the insurer on a monthly basis, then the policy shall provide that, in the event of termination of the policy, termination notice shall be given to the insured debtor at least thirty (30) days prior to the effective date of termination, except where replacement of the coverage by the same or another insurer in the same or greater amount takes place without lapse of coverage. The insurer shall provide or cause to be provided this required information to the debtor.

(d) If the creditor adds identifiable insurance charges or premiums for consumer credit insurance to the debt, and any direct or indirect finance, carrying, credit, or service charge is made to the debtor on the insurance charges or premiums, the creditor must remit and the insurer shall collect the premium within sixty (60) days after it is added to the debt.

(e) If the debt is discharged due to refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the refinanced debt. In all cases of termination prior to scheduled maturity, a refund of all unearned premium or unearned insurance charges paid by the debtor shall be paid or credited to the debtor as provided in section 8 of this rule. In any refinancing of the debt, the effective date of the coverage as respects any policy provision shall be deemed to be the first date on which the debtor became insured under the policy with respect to the debt that was refinanced, at least to the extent of the amount and term of the debt outstanding at the time of refinancing of the debt.

(f) A provision in an individual policy or group certificate that sets a maximum limit on total claim payments must apply only to that individual policy or group certificate.

(g) If a debtor prepays the debt in full, then any consumer credit insurance covering the debt shall be terminated and an appropriate refund of the consumer credit insurance premium shall be paid or credited to the debtor in accordance with section 8 of this rule. However, if the prepayment is a result of death or any other lump sum consumer credit insurance payment, no refund shall be required for the coverage under which the lump sum was paid. If a claim under credit accident and health coverage is in progress at the time of prepayment, the amount of refund may be determined as if the prepayment did not occur until the payment of benefits terminates. No refund need be paid during any period of disability for which credit accident and health benefits are payable. A refund shall be computed as if prepayment occurred at the end of the disability period.

(h) If a creditor has opened a line of credit for a debtor and, if permitted under IC 27-8-4-4(A) or IC 27-1-12-37(2)(F), is charging for this line of credit rather than the amount of debt in the event of the death of the debtor, the insured amount due is the amount of the established amount of credit against which premium was last charged. *(Department of Insurance; 760 IAC 1-5.1-3; filed Sep 9, 2002, 3:00 p.m.: 26 IR 20, eff Jan 1, 2003)*

760 IAC 1-5.1-4 Determination of reasonableness of benefits in relation to premium charge

Authority: IC 27-1-3-7; IC 27-8-4-12
Affected: IC 24-4.5-4-102

Sec. 4. (a) Benefits provided by consumer credit insurance policies must be reasonable in relation to the premium charged. This requirement is satisfied if the premium rate charged develops or may reasonably be expected to develop a loss ratio of not less than fifty-five percent (55%). With the exception of deviations approved under section 10 of this rule, the rates shown in sections 6 and 7 of this rule, as adjusted pursuant to section 9 of this rule, shall be presumed to satisfy this loss ratio standard. Anticipated losses that develop or are expected to develop a loss ratio of not less than fifty-five percent (55%) shall be presumed reasonable. Any insurer filing a deviation in accordance with section 10 of this rule must satisfy the fifty-five percent (55%) loss ratio standard for their total consumer credit insurance business.

(b) If any insurer files for approval of any form providing coverage different than that described in sections 6 and 7 of this rule, the insurer shall demonstrate to the satisfaction of the commissioner that the premium rates to be charged for such coverage are:

(1) reasonably expected to develop a loss ratio of not less than fifty-five percent (55%); or

(2) actuarially consistent with the rates used for standard coverages.

(Department of Insurance; 760 IAC 1-5.1-4; filed Sep 9, 2002, 3:00 p.m.: 26 IR 21, eff Jan 1, 2003)

760 IAC 1-5.1-5 Compensation limitations

Authority: IC 27-1-3-7; IC 27-8-4-12
Affected: IC 24-4.5-4-102

Sec. 5. (a) An insurer shall not pay compensation in excess of forty percent (40%) of the net written prima facie premium of which not more than thirty-three *[percent]* (33%) of net written prima facie premium may be paid to a creditor.

(b) For purposes of subsection (a), prima facie premium means premium using the premium rates set out in sections 6 and 7 of this rule, or actuarially consistent premium rates for plans not described in sections 6 and 7 of this rule, without any adjustment pursuant to section 10 of this rule. *(Department of Insurance; 760 IAC 1-5.1-5; filed Sep 9, 2002, 3:00 p.m.: 26 IR 21, eff Jan 1, 2003)*

760 IAC 1-5.1-6 Credit life insurance rates

Authority: IC 27-1-3-7; IC 27-8-4-12
Affected: IC 24-4.5-4-102

Sec. 6. (a) Subject to the conditions and requirements in subsection (b) and section 10 of this rule, the following prima facie rates are considered to meet the requirements of section 4 of this rule, and may be used without filing additional actuarial support:

(1) For monthly outstanding balance basis, sixty-nine cents ($0.69) per month per one thousand dollars ($1,000) of outstanding insured debt on single life and one dollar and fifteen cents ($1.15) per month per one thousand dollars ($1,000) of outstanding insured debt on joint life if premiums are payable on a monthly outstanding balance basis.

(2) If the premium is charged on a single premium basis, the rate shall be computed according to the following formula or according to a formula approved by the commissioner that produces rates substantially the same as those produced by the following formula:

$$S_p = \sum_{t=1}^{n} \left(\frac{O_p}{10} \times \frac{I_t}{I_i} \times (v^{t-1}) \right)$$

$$v = \frac{1}{1+(dis)}$$

Where:
- S_p = Single premium per one hundred dollars ($100) of initial consumer credit life insurance coverage.
- O_p = 0.69, the prima facie consumer credit life insurance premium rate for monthly outstanding balance coverage from subdivision (1).
- I_t = The scheduled amount of insurance for month t.
- I_i = Initial amount of insurance. For a net insurance policy, I_i equals the initial principal balance of the loan.
- dis = 0.0044, representing an annual discount rate of 5.0% for interest plus four-tenth *[sic., four-tenths]* of one percent (0.4%) for mortality.
- n = The number of months in the term of the insurance.

(3) If the benefits provided are other than those described in this section, premium rates for such benefits shall be actuarially consistent with the rates provided in subdivisions (1) and (2).

(4) The prima facie rates included in this subsection and any other rates approved for use that are computed in accordance with the formula in subdivision (2) are presumed sufficient to provide for up to two (2) months of delinquencies. Therefore, the determination of the premium shall not reflect delinquencies.

(b) The premium rates in subsection (a) shall apply to contracts providing credit life insurance that are offered to all eligible debtors, that do not require evidence of individual insurability from any eligible debtor electing to purchase coverage within thirty (30) days of the date the debtor becomes eligible, and that contain the following provisions:

(1) Coverage for death by whatever means caused, except that coverage may exclude death resulting from any of the following:

(A) War or any act of war.
(B) Suicide within six (6) months after the effective date of the coverage.
(C) A preexisting condition or conditions. For the purpose of this subsection, the following apply:
(i) "Preexisting condition" means any condition for which the debtor received medical advice or treatment within six (6) months preceding the effective date of coverage.
(ii) No preexisting condition exclusion shall apply unless:
(AA) death is caused by or substantially contributed to by the preexisting condition; and
(BB) death occurs within six (6) months following the effective date of coverage.
(iii) A preexisting condition exclusion shall apply only if and to the extent that the amount of coverage to which it would otherwise apply (in the absence of this limitation) exceeds one thousand dollars ($1,000).

(2) For the exclusions listed in subdivisions (1)(B) and (1)(C), the effective date of coverage for each part of the insurance attributable to a different advance or a charge to the plan account is the date on which the advance or charge occurs.

(3) At the option of the insurer and in lieu of a preexisting condition exclusion on insurance written in connection with open-ended consumer credit, a provision may be included to limit the amount of insurance payable on death due to natural causes to the balance as it existed six (6) months prior to the date of death if there has been one (1) or more increases in the outstanding balance during the six (6) month period and if evidence of individual insurability has not been required in the six (6) month period prior to the date of death. This provision applies only if and to the extent that the amount of coverage to which it would otherwise apply (in the absence of this limitation) exceeds one thousand dollars ($1,000).

(4) An age restriction providing that no insurance will become effective on debtors on or after the attainment of age sixty-six (66) and that all insurance will terminate upon attainment by the debtor of age sixty-six (66).

(c) The insurer shall apply rates as follows:

(1) If the insurer, its agent, or the application form for credit life insurance does not request or require that the debtor provide evidence of insurability, then the premium rates deemed reasonable will be the prima facie rates in subsection (a).

(2) Except as provided in subdivision (3), if the insurer, its agent, or the application form for credit life insurance requests or requires that the debtor provide evidence of insurability and the initial amount of insurance is fifteen thousand dollars ($15,000) or less, then the premium rates deemed reasonable will be the rates in subsection (a) multiplied by ninety percent (90%).

(3) If the insurer, its agent, or the application form for credit life insurance requests or requires that the debtor provide evidence of insurability and the initial amount of insurance is greater than fifteen thousand dollars ($15,000) or the applicant elects to purchase coverage more than thirty (30) days after the date the debtor became eligible under a group plan of insurance, then the premium rates deemed reasonable will be the prima facie rates in subsection (a). For policies insuring open lines of credit, the insurer may require evidence of insurability for commitments that increase the outstanding debt above fifteen thousand dollars ($15,000).

(d) Insurers may use the same application forms for credit life insurance whether or not underwriting questions are asked pursuant to subsection (c). The commissioner will presume that any application form for which all relevant underwriting questions have been left unanswered represents a policy that has not been underwritten and for which prima facie rates are permissible. A form for which any relevant underwriting questions have been answered or filled in represents a policy for which premium decreases pursuant to subsection (c) are required. Insurers should maintain in their files their rules for those circumstances where underwriting questions shall be asked. Those rules shall be communicated to and followed by the insurer's agents and producers. *(Department of Insurance; 760 IAC 1-5.1-6; filed Sep 9, 2002, 3:00 p.m.: 26 IR 22, eff Jan 1, 2003)*

760 IAC 1-5.1-7 Credit accident and health insurance rates

Authority: IC 27-1-3-7; IC 27-8-4-12
Affected: IC 24-4.5-4-102

Sec. 7. (a) Subject to the conditions and requirements in subsection (b) and section 10 of this rule, the following prima facie rates are considered to meet the requirements of section 4 of this rule, and may be used without filing additional actuarial support:

(1) If premiums are payable on a single-premium basis for the duration of the coverage, the prima facie rate per one hundred dollars ($100) of initial insured debt for single accident and health is as set forth in the following table and rates for monthly periods other than those listed shall be interpolated or extrapolated:

Original Number of Equal Monthly Installments	14 Day Retroactive Policy	14 Day Nonretroactive Policies	30 Day Retroactive Policies	30 Day Nonretroactive Policies
6	1.54	1.01	1.04	0.79
12	2.04	1.42	1.40	1.05
24	2.73	1.97	1.97	1.37
36	3.35	2.57	2.53	1.83
48	3.71	2.93	2.89	2.16
60	4.00	3.22	3.19	2.44
72	4.27	3.47	3.45	2.69
84	4.49	3.71	3.68	2.93
96	4.71	3.93	3.89	3.15
108	4.92	4.13	4.10	3.36
120	5.12	4.32	4.29	3.55

(2) If premiums are paid on the basis of a premium rate per month per thousand of outstanding insured gross debt, these premiums shall be computed according to the following formula or according to a formula approved by the commissioner, that produces rates actuarially consistent with the single premium rates in subdivision (1):

$$OP_n = \frac{10SP_n}{\left\{\sum_{t=1}^{n}\frac{(v^{t-1}\times(n-t+1))}{n}\right\}}$$

$$v = \frac{1}{1+(dis)}$$

Where: SP_n = Single premium rate per one hundred dollars ($100) of initial insured debt repayable in n equal monthly installments as shown in subdivision (1).

OP_n = Monthly outstanding balance premium rate per one thousand dollars ($1,000).

n = The number of months in the term of the insurance.

dis = 0.0041, representing an annual discount rate of five percent (5.0%) for interest.

(3) If the coverage provided is a constant maximum indemnity for a given period of time, the actuarial equivalent of subdivisions (1) and (2) shall be used.

(4) If the coverage provided is a combination of a constant maximum indemnity for a given period of time after which the maximum indemnity begins to decrease in even amounts per month, an appropriate combination of the premium rate for a constant maximum indemnity for a given period of time, and the premium rate for a maximum indemnity that decreases in even amounts per month shall be used.

(5) The outstanding balance rate for credit accident and health insurance may be either a term-specified rate or may be a single composite term outstanding balance rate.

(b) Subject to the conditions and requirements in subsection (c) and section 10 of this rule, the prima facie rates for credit accident and health insurance calculated as shown in this subsection are considered to meet the requirements of section 4 of this rule in the situation where the insurance is written on an open-end loan. These prima facie rates and the formulae used to calculate them may be used without filing additional actuarial support. Other formulae to convert from a closed-end credit rate to an open-end credit rate may be used if approved by the commissioner. The following establishes the prima facie rates for credit accident and health insurance on an open-end loan:

(1) If the maximum benefit of the insurance equals the net debt on the date of disability, the term of the loan is calculated according to the following formula:

1/(minimum payment percent).

The prima facie rate is determined by applying the calculated term to the rates shown in subsection (a). A composite minimum payment percentage may be used in place of the minimum payment percentage for a specific credit transaction.

(2) If the maximum benefit of the insurance equals the outstanding balance of the loan on the date of disability plus any interest accruing on that amount during disability, the term of the insurance (n) is estimated by using the following formula:

$$n = \ln \{1 - (1000i / \times)\} / \ln(v)$$

Where: i = Interest rate on the account or a composite interest rate used for the type of policy.

x = Monthly payment per one thousand dollars ($1,000) of coverage consistent with the term calculated in this subdivision.

$$v = 1/(1 + i)$$

The calculated value of the term is used to look up an initial rate in subsection (a). The final prima facie rate is calculated by multiplying the initial rate by the following:

$$\text{the adjustment } n/a_n$$

Where: n = The term calculated as per the following equation:

$$a_n = (1 - v^n)/i$$

As an alternative to the calculation required in subsection (b) *[this subsection]*, a composite rate for open-end revolving loans may be filed for approval by the commissioner. This rate must be actuarially equivalent to the prima facie rate.

(c) If the accident and health coverage is sold on a joint basis (involving two (2) people), the rate for the joint coverage shall be filed with the commissioner prior to use.

(d) If the benefits provided are other than those described in subsection (a) or (b), rates for those benefits shall be actuarially consistent with rates provided in subsection *[sic., subsections]* (a) and (b).

(e) The premium rates in subsection (a) shall apply to contracts providing credit accident and health insurance that are offered to all eligible debtors, that do not require evidence of individual insurability from any eligible debtor electing to purchase coverage within thirty (30) days of the date the debtor becomes eligible and that contain the following provisions:

(1) Coverage for disability by whatever means caused, except that coverage may be excluded for disabilities resulting from:

(A) normal pregnancy;

(B) war or any act of war;

(C) elective surgery;

(D) intentionally self-inflicted injury;

(E) sickness or injury caused by or resulting from the use of alcoholic beverages or narcotics (including hallucinogens) unless they are administered on the advice of and taken as directed, by a licensed physician other than the insured;

(F) flight in any aircraft other than a commercial scheduled aircraft; or

(G) a preexisting condition.

(2) For the exclusion listed in subdivision (1)(G), the effective date of coverage for each part of the insurance attributable to a different advance or a charge to the plan account is the date on which the advance or charge occurs.

(3) A definition of disability providing that for the first twelve (12) months of disability, total disability shall be defined as the inability to perform the essential functions of the insured's own occupation. Thereafter, it shall mean the inability of the insured to perform the essential functions of any occupation for which he or she is reasonably suited by virtue of education, training, or experience.

(4) No employment requirement more restrictive than one requiring that the debtor be employed full time on the effective date of coverage and for at least twelve (12) consecutive months prior to the effective date of coverage. As used in this subdivision, "full time" means a regular work week of not less than thirty (30) hours.

(5) An age restriction providing that no insurance will become effective on debtors on or after the attainment of age sixty-six (66) and that all insurance will terminate upon attainment by the debtor of age sixty-six (66).

(6) A daily benefit of not less than one-thirtieth ($^1/_{30}$) of the monthly benefit payable under the policy.

(f) Requirements for applying rates shall be as follows:

(1) If the insurer, its agent, or the application form for credit life insurance does not request or require that the debtor provide evidence of insurability, then the premium rates deemed reasonable will be the prima facie rates in subsection (a).

(2) Except as provided in subdivision (3), if the insurer, its agent, or the application form for credit life insurance requests or requires that the debtor provide evidence of insurability and the initial amount of insurance is fifteen thousand dollars ($15,000) or less, then the premium rates deemed reasonable will be the rates in subsection (a) multiplied by ninety percent (90%).

(3) If the insurer, its agent, or the application form for credit life insurance requests or requires that:

(A) the debtor provide evidence of insurability and the initial amount of insurance is greater than fifteen thousand dollars ($15,000); or

(B) the applicant elects to purchase coverage more than thirty (30) days after the date the debtor became eligible under a group plan of insurance;

then the premium rates deemed reasonable will be the prima facie rates in subsection (a). For policies insuring open lines of credit, the insurer may require evidence of insurability for commitments that increase the outstanding debt above fifteen thousand dollars ($15,000).

(g) Insurers may use the same application forms for credit accident and health insurance whether or not underwriting questions are asked pursuant to subsection (f). The commissioner will presume that any application form for which all relevant underwriting questions have been left unanswered represents a policy that has not been underwritten and for which prima facie rates are permissible. A form for which any relevant underwriting questions have been answered or filled in represents a policy for which premium decreases pursuant to subsection (f) are required. Insurers should maintain in their files their rules for those circumstances where underwriting questions shall be asked. Those rules shall be communicated to and followed by the insurer's agents or other producers. *(Department of Insurance; 760 IAC 1-5.1-7; filed Sep 9, 2002, 3:00 p.m.: 26 IR 23, eff Jan 1, 2003; errata filed Jun 10, 2003, 2:45 p.m.: 26 IR 3345)*

760 IAC 1-5.1-8 Refund formulas

Authority: IC 27-1-3-7; IC 27-8-4-12
Affected: IC 24-4.5-4-102; IC 27-8-4-8

Sec. 8. (a) In the event of termination, no charge for consumer credit insurance may be made for the first fifteen (15) days of a month and a full month may be charged for sixteen (16) days or more of a month.

(b) The requirement of IC 27-8-4-8(B) that refund formulas be filed with the commissioner shall be considered fulfilled if the refund formulas are set forth in the individual policy or group certificate filed with the commissioner.

(c) Refund formulas must develop refunds that are at least as favorable to the debtor as refunds equal to the premium cost of scheduled benefits subsequent to the date of cancellation or termination, computed at the schedule of premium rates in effect on the date of issue.

(d) No refund of one dollar ($1) or less need be made. *(Department of Insurance; 760 IAC 1-5.1-8; filed Sep 9, 2002, 3:00 p.m.: 26 IR 25, eff Jan 1, 2003)*

760 IAC 1-5.1-9 Experience reports and adjustment of prima facie rates

Authority: IC 27-1-3-7; IC 27-8-4-12
Affected: IC 24-4.5-4-102

Sec. 9. (a) Each insurer doing insurance business in this state shall annually file with the commissioner and the National Association of Insurance Commissioners (NAIC) support and services office a report of consumer credit insurance written on a calendar year basis. The report shall utilize the Credit Insurance Supplement–Annual Statement Blank as approved by the NAIC, and shall contain data separately for each state, rather than an allocation of the company's countrywide experience. The filing shall be made in accordance with and no later than the due date in the instructions to the annual statement.

(b) The commissioner will, on a triennial basis, review the loss ratio standards set forth in section 4 of this rule and the prima facie rates set forth in sections 6 and 7 of this rule and determine the rate of expected claims on a statewide basis, compare such rate of expected claims with the rate of actual claims for the preceding three (3) years determined from the incurred claims and earned premiums at prima facie rates reported in the annual statement supplement or other available source, and publish in the Indiana Register the adjusted actual statewide prima facie rates to be used by insurers during the next triennium. The rates will reflect the difference between actual claims based on experience and expected claims based on the loss ratio standards set forth in section 4 of this rule applied to the prima facie rates set forth in sections 6 and 7 of this rule. If the commissioner determines, at the conclusion of the triennial review, that the rate adjustment is de minimus *[sic., de minimis]*, then the statewide prima facie rate will not be changed. The commissioner will publish a statement that the rate will not change and the results of the rate review required by this subsection.

(c) The commissioner will, on a triennial basis, review the discount rates for interest included in the formulae in sections 6(a) and 7(a) of this rule, and adjust those discount rates to equal the average of the rates being paid at that time on three (3) year United States Treasury notes as reported in the Wall Street Journal on the last day of sale in the most recent three (3) calendar years. The

commissioner shall publish the revised discount rates in the Indiana Register. If the commissioner determines, at the conclusion of the triennial review, that the rate adjustment is de minimus *[sic., de minimis]*, then the discount rate will not be changed. *(Department of Insurance; 760 IAC 1-5.1-9; filed Sep 9, 2002, 3:00 p.m.: 26 IR 25, eff Jan 1, 2003)*

760 IAC 1-5.1-10 Use of rates; direct business only

Authority: IC 27-1-3-7; IC 27-8-4-12
Affected: IC 24-4.5-4-102

Sec. 10. (a) An insurer that files rates or has rates on file that are equivalent to the prima facie rates shown in sections 6 and 7 of this rule, to the extent adjusted pursuant to section 9 of this rule, may use those rates without further proof of their reasonableness.

(b) An insurer may file for approval of and use rates that are higher than the prima facie rates shown in sections 6 and 7 of this rule, to the extent adjusted pursuant to section 9 of this rule, as long as the filed rates are consistent with section 4 of this rule. If rates higher than the prima facie rates shown in sections 6 and 7 of this rule, to the extent adjusted pursuant to section 9 of this rule, are filed for approval, the filing shall specify the account or accounts to which the rates apply. The rates may be applied:

(1) uniformly to all accounts of the insurer;

(2) on an equitable basis approved by the commissioner to only one (1) or more accounts of the insurer for which the experience has been less favorable than expected; or

(3) according to a case-rating procedure on file with the commissioner.

(c) The approval period of deviated rates are established as follows:

(1) A deviated rate will be in effect for a period of time not longer than the experience period used to establish the rate, that is, one (1) year, two (2) years, or three (3) years. An insurer may file for a new rate before the end of a rate period, but not more often than once during any twelve (12) month period.

(2) Notwithstanding the provision of subsection (a), if an account changes insurers, the rate approved to be used for the account by the prior insurer is the maximum rate that may be used by the succeeding insurer for the remainder of the rate approval period approved for the prior insurer or until a new rate is approved for use on the account, if sooner.

(d) An insurer may at any time use a rate for an account that is lower than its filed rate without notice to the commissioner. *(Department of Insurance; 760 IAC 1-5.1-10; filed Sep 9, 2002, 3:00 p.m.: 26 IR 26, eff Jan 1, 2003)*

760 IAC 1-5.1-11 Supervision of consumer credit insurance operations

Authority: IC 27-1-3-7; IC 27-8-4-12
Affected: IC 24-4.5-4-102

Sec. 11. (a) Each insurer transacting credit insurance in this state shall be responsible for conducting a thorough periodic review of creditors with respect to their credit insurance business with such creditors, to assure compliance with the insurance laws of this state and the rules promulgated by the commissioner.

(b) Written records of such reviews shall be maintained by the insurer for a period of no less than five (5) years for review by the commissioner. *(Department of Insurance; 760 IAC 1-5.1-11; filed Sep 9, 2002, 3:00 p.m.: 26 IR 26, eff Jan 1, 2003)*

760 IAC 1-5.1-12 Prohibited transactions

Authority: IC 27-1-3-7; IC 27-8-4-12
Affected: IC 24-4.5-4-102; IC 27-4-1

Sec. 12. The following practices, when engaged in by insurers in connection with the sale or placement of consumer credit insurance, or as an inducement thereto, shall be considered unfair methods of competition subject to the provisions of IC 27-4-1:

(1) The offer or grant by an insurer to a creditor of any special advantage or any service not set out in either the group insurance contract or in the agency contract, other than the payment of agent's commissions.

(2) Deposit by an insurer of money or securities without interest or at a lesser rate of interest than is currently being paid by the creditor, bank, or financial institution to other depositors of like amounts for similar durations. This subsection shall not be construed to prohibit the maintenance by an insurer of such demand deposits or premium deposit accounts as are reasonably

necessary for use in the ordinary course of the insurer's business.
(Department of Insurance; 760 IAC 1-5.1-12; filed Sep 9, 2002, 3:00 p.m.: 26 IR 26, eff Jan 1, 2003)

760 IAC 1-5.1-13 Implementation

Authority: IC 27-1-3-7; IC 27-8-4-12
Affected: IC 24-4.5-4-102

Sec. 13. (a) Approval of all forms and premium rates not in compliance with this rule is hereby withdrawn as of January 1, 2003.

(b) Any deviations thought to be appropriate by an insurer as a result of promulgation of this rule shall be filed in accordance with the provisions of section 10 of this rule no later than October 1, 2002. *(Department of Insurance; 760 IAC 1-5.1-13; filed Sep 9, 2002, 3:00 p.m.: 26 IR 26)*

Rule 6. Surety Insurance, Bail Bondsmen and Runners

760 IAC 1-6-1 Authority to promulgate rule; purpose of rule (Repealed)

Sec. 1. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-2 Felons deemed untrustworthy (Repealed)

Sec. 2. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-3 Loitering considered soliciting business (Repealed)

Sec. 3. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-4 Solicitation by agent prohibited (Repealed)

Sec. 4. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-5 Runners licensed by bondsman; limitations (Repealed)

Sec. 5. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-6 Disqualification by employment of one whose license is revoked or suspended (Repealed)

Sec. 6. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-7 Power of attorney from surety company (Repealed)

Sec. 7. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-8 Premium limited; return to defendant (Repealed)

Sec. 8. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-9 Charges other than premium prohibited (Repealed)

Sec. 9. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-10 Requested reports to commissioner; inspection of records (Repealed)

Sec. 10. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-11 Attachment of financial statement to renewal application required (Repealed)

Sec. 11. *(Repealed by Department of Insurance; filed Sep 9, 1982, 1:57 pm: 5 IR 2230)*

760 IAC 1-6-12 Filing of premium rate by first-time applicant required; change of rate (Repealed)

Sec. 12. *(Repealed by Department of Insurance; filed Sep 9, 1982, 1:57 pm: 5 IR 2230)*

760 IAC 1-6-13 Disclosure of status as bondsman (Repealed)

Sec. 13. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-14 Guaranteeing bail in advance of offense prohibited (Repealed)

Sec. 14. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-15 Gifts to public officials or prisoners prohibited; exceptions (Repealed)

Sec. 15. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-16 Records (Repealed)

Sec. 16. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-17 Affidavit for collateral (Repealed)

Sec. 17. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-18 Contract terms and conditions; form (Repealed)

Sec. 18. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

760 IAC 1-6-19 Notice of act and rule (Repealed)

Sec. 19. *(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)*

Rule 6.1. Bail Bondsmen and Runners (Repealed)

(Repealed by Department of Insurance; filed Jul 28, 1994, 4:00 p.m.: 17 IR 2864)

Rule 6.2. Bail Agents and Recovery Agents

760 IAC 1-6.2-1 Authority

Authority: IC 27-10-2-1
Affected: IC 27-10-2-1

Sec. 1. This rule is adopted and promulgated by the department of insurance under IC 27-10-2-1. *(Department of Insurance;*

760 IAC 1-6.2-1; filed Jul 28, 1994, 4:00 p.m.: 17 IR 2862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)

760 IAC 1-6.2-2 Soliciting business; actions considered

Authority: IC 27-10-2-1
Affected: IC 27-10-3-18; IC 27-10-4-2

Sec. 2. (a) A bail agent or a recovery agent shall be deemed to be soliciting business in violation of the law if the bail agent or recovery agent, while present in any jail, sheriff's office, constable's office, police station, courthouse, or courtroom, without invitation, speaks with, approaches, or communicates with, in writing or otherwise, any person, with the intent to solicit bail business.

(b) This rule does not prevent a bail agent or a recovery agent from being in and around a jail, sheriff's office, constable's office, police station, courthouse, or courtroom when called there by a client or for the purpose of seeing that the defendants on whom the bonds have been written are present. *(Department of Insurance; 760 IAC 1-6.2-2; filed Jul 28, 1994, 4:00 p.m.: 17 IR 2862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-6.2-3 Solicitation in bail agent's behalf by unlicensed person

Authority: IC 27-10-2-1
Affected: IC 27-10-4-2

Sec. 3. (a) Any licensed bail agent who knowingly permits any person, not licensed as a bail agent, to solicit business in the agent's behalf as prohibited by law, shall be deemed to be in violation of the law.

(b) Any person, not licensed as a bail agent, who is connected with a bail agent or an authorized surety company and who makes unsolicited contact with a defendant prior to the approval or acceptance of the bond by a proper officer, shall be deemed to be soliciting bail bonds without a license. *(Department of Insurance; 760 IAC 1-6.2-3; filed Jul 28, 1994, 4:00 p.m.: 17 IR 2862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-6.2-4 Power of attorney

Authority: IC 27-10-2-1
Affected: IC 27-10-4-5

Sec. 4. Any licensed bail agent acting on behalf of an authorized surety company must attach to each bond a numbered, duly executed power of attorney from the surety company in an amount of at least the penalty of the bond. *(Department of Insurance; 760 IAC 1-6.2-4; filed Jul 28, 1994, 4:00 p.m.: 17 IR 2862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-6.2-5 Receipts for receiving and returning collateral

Authority: IC 27-10-2-1
Affected: IC 27-10-2-14

Sec. 5. (a) When a bail agent accepts collateral, the agent shall give a written receipt. The receipt shall:

(1) identify the bond for which the collateral was received;
(2) give a full description of the collateral;
(3) name the individual giving the collateral; and
(4) specify the terms for redemption of the collateral.

(b) When a bail agent returns collateral, the agent shall give a written receipt. The receipt shall:

(1) identify the bond for which the collateral was received;
(2) give a full description of the collateral returned; and
(3) include the signature of the person to whom the collateral was returned.

(Department of Insurance; 760 IAC 1-6.2-5; filed Jul 28, 1994, 4:00 p.m.: 17 IR 2862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)

760 IAC 1-6.2-6 Manner of conducting business; capacity in which bail agent acts

Authority: IC 27-10-2-1
Affected: IC 27-10-3-8

Sec. 6. Every bail agent shall conduct the agent's business in such a manner that the public and those dealing with the agent shall be aware of the capacity in which the agent is acting. *(Department of Insurance; 760 IAC 1-6.2-6; filed Jul 28, 1994, 4:00 p.m.: 17 IR 2862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-6.2-7 Gifts to public officials or prisoners prohibited; gifts to relatives permitted

Authority: IC 27-10-2-1
Affected: IC 27-10-4-2

Sec. 7. No bail agent shall give, directly or indirectly, any gift of any kind to:
(1) a public official;
(2) an employee of any government agency; or
(3) a prisoner in any jail or place of detention.
This section shall not prevent the customary giving of gifts to relatives by blood or marriage. *(Department of Insurance; 760 IAC 1-6.2-7; filed Jul 28, 1994, 4:00 p.m.: 17 IR 2863; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-6.2-8 Records must be kept; information required

Authority: IC 27-10-2-1
Affected: IC 27-10-2-14

Sec. 8. (a) Every bail agent shall keep complete records of all business done under authority of the agent's license or under the authority of the license of any bail agent employed by the agent. All records kept by such bail agent, including all documents and copies thereof, shall be open to inspection or examination by the commissioner of the department of insurance or his representatives at all reasonable times at the principal place of business of the bail agent as designated in the bail agent's license.

(b) Such records for each bail bond executed shall include, but not be limited to, the following:
(1) The original application for a bond.
(2) A copy of the power of attorney used pursuant to the application and issued bond.
(3) A dated, serially numbered receipt for premium payment evidencing the power of attorney used for the bond, signed by both the paying individual and receiving bail agent.
(4) Collateral receipts, if any, issued for each bond.
(5) Complete accounting records reflecting all premiums received and disbursements.
(Department of Insurance; 760 IAC 1-6.2-8; filed Jul 28, 1994, 4:00 p.m.: 17 IR 2863; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)

760 IAC 1-6.2-9 Acceptance of collateral for bail bond; collateral receipt required

Authority: IC 27-10-2-1
Affected: IC 27-10-2

Sec. 9. Each bail agent who accepts collateral security for a bail bond shall, for such bail bond written, make and attach to each such bail bond a copy of receipt for such collateral received. *(Department of Insurance; 760 IAC 1-6.2-9; filed Jul 28, 1994, 4:00 p.m.: 17 IR 2863; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-6.2-10 Contract between principal and surety; terms and conditions

Authority: IC 27-1-3-7
Affected: IC 27-10-2-3; IC 27-10-4-4

Sec. 10. (a) The terms and conditions of all contracts entered into between a principal and a surety for a bail bond shall set

forth:

(1) the bond number;

(2) the date;

(3) the amount of the premium; and

(4) the name of the surety company;

on the form prescribed by the commissioner of the department of insurance. A specimen form of such terms and conditions appears in subsection (b). Any other form may be used upon the approval of the commissioner of the department of insurance which meets the minimum standards of the specimen form.

(b) The following is an example of the terms and conditions of a contract between a principal and a surety:

TERMS AND CONDITIONS

The following terms and conditions are an integral part of this application for appearance bond # _____ dated _____ for which _____ Surety Company or its agents shall receive a premium in the amount of _____ ($_____) Dollars, and the parties agree that said appearance bond is conditioned upon full compliance by the principal with all said terms and conditions and is a part of said bond and application therefor.

1. _____ Surety Company as bail, shall have control and jurisdiction over the principal during the term for which the bond is executed and shall have the right to apprehend, arrest, and surrender the principal to the proper officials at any time as provided by law.

2. It is understood and agreed that the happening of any one of the following events shall constitute a breach of principal's obligations to _____ Surety Company hereunder, and _____ Surety Company shall have the right to forthwith apprehend, arrest, and surrender principal, and principal shall have no right to any refund of premium whatsoever. Said events which shall constitute a breach of principal's obligations hereunder are:

(a) If principal shall depart the jurisdiction of the court without the written consent of the court and _____ Surety Company or its agent.

(b) If principal shall move from one address to another within the State of Indiana without notifying _____ Surety Company or its agent in writing prior to said move.

(c) If principal shall commit any act which shall constitute reasonable evidence of principal's intention to cause a forfeiture of said bond.

(d) If principal shall make any material false statement in the application.

(e) If principal is arrested and incarcerated for any offense other than a minor traffic violation.

Signed, sealed, and delivered this _____ day of _____ 19_____

_____
Signature of Applicant

_____
Mailing Address

(Department of Insurance; 760 IAC 1-6.2-10; filed Jul 28, 1994, 4:00 p.m.: 17 IR 2863; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)

Rule 7. Segregated Investment Account Contracts

760 IAC 1-7-1 Authority to promulgate rule; purpose and applicability of rule

Authority: IC 27-1-3-7
Affected: IC 27-1-5-1

Sec. 1. Authority and Purpose. Pursuant to the authority given by the Insurance Laws of the State of Indiana, particularly Acts 1935, Chapter 162, Section 14 *[IC 27-1-3-7]*, the Department of Insurance (the "Department") hereby makes and promulgates the following rules and regulations *[760 IAC 1-7]*, declaring that the conduct or transaction of business by an insurance company subject to the laws of the State of Indiana in any manner contrary to these regulations *[760 IAC 1-7]* shall be deemed to be an unsafe manner, and that it is the purpose of these rules and regulations *[760 IAC 1-7]* to establish safe and sound methods for the transaction of the type of business to which they pertain.

On and after the effective date hereof, these rules and regulations *[760 IAC 1-7]* shall apply to insurance companies issuing

or delivering within this state contracts of the nature described in Class I(c) of Section 59 *[IC 27-1-5-1]* of the Insurance Laws of the State of Indiana (hereinafter referred to as "Class I(c) Contracts"). *(Department of Insurance; Reg 7,I; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 96; filed Mar 18, 1970, 10:20 am: Rules and Regs. 1971, p. 204; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-7-2 Qualification of insurer; factors

Authority: IC 27-1-3-7
Affected: IC 27-1-5-1

Sec. 2. Qualifications of Insurer. No insurance company shall issue or deliver Class I(c) Contracts within this State unless and until it shall have qualified, to the reasonable satisfaction of the Department, to issue or deliver such contracts. In any determination of the qualifications of a company, the following factors shall be considered:

(a) the history, financial status and reputation of the company

(b) the character and competence of the directors and officers of the company

(c) whether, in the case of a company not organized under the laws of the State of Indiana, the regulation provided by the laws of its domicile provides a degree of protection to the public and to holders of its contracts substantially equal to that provided by the laws of this state and the rules and regulations issued by the Department pursuant thereto.

(Department of Insurance; Reg 7,II; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 96; filed Mar 18, 1970, 10:20 am: Rules and Regs. 1971, p. 205; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)

760 IAC 1-7-3 Illustrations of benefits payable; restrictions

Authority: IC 27-1-3-7
Affected: IC 27-1-5-1

Sec. 3. Illustration of Benefits Payable. No illustration shall misrepresent the terms of any Class I(c) Contract or the benefits or advantages promised thereby.

Illustration of benefits payable under any Class I(c) Contract shall not involve projections of past investment experience into the future or attempted predictions of future investment experience.

Illustrations of benefits payable, the amount of which may vary by reason of experience factors derived from a segregated investment account, shall be reasonable and shall contain a clear statement that said benefits may vary and are not guaranteed as to fixed dollar amount. *(Department of Insurance; Reg 7,III; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 97; filed Mar 18, 1970, 10:20 am: Rules and Regs. 1971, p. 205; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-7-4 Filing of forms; disapproval by department

Authority: IC 27-1-3-7
Affected: IC 27-1-5-1

Sec. 4. Filing, Disapproval and Withdrawal of Forms. No Class I(c) Contract shall be issued or delivered in this state until a copy of the form thereof and, in the case of such a contract on a group basis, a copy of the form of any certificate issued pursuant thereto, and a copy of the form of the application for a Class I(c) Contract shall have been filed with the Department. The Department shall disapprove of, or withdraw from file, any such forms which are ambiguous, misleading, or deceptive, or likely to mislead or deceive the policyholder, certificate holder, or applicant. *(Department of Insurance; Reg 7,IV; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 97; filed Mar 18, 1970, 10:20 am: Rules and Regs. 1971, p. 205; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-7-5 Accounting; transfers between accounts

Authority: IC 27-1-3-7
Affected: IC 27-1-5-1

Sec. 5. Any insurance company which issues Class I(c) contracts shall establish such administrative and accounting procedures

as are necessary to properly identify a segregated investment account of the company derived from or in relation to contributions, premiums or considerations received by it under Class I(c) contracts. A Class I(c) contract may provide that all or a portion of the segregated investment account is derived from a designated percentage of specific assets in the company's general investment portfolio. No insurance company which issues Class I(c) contracts shall transfer assets between segregated investment accounts or between any such account and other accounts except for the purposes of (1) conducting the business of such account in accordance with provisions of the Class I(c) contract, or (2) making the adjustments necessitated by the Class I(c) contract and the mortality experience adjustment specified in Section 59 (IC 27-1-5-1) of the Indiana insurance laws, and then only if such transfers are made–

(i) by a transfer of cash, or

(ii) by a transfer of securities having a value which can readily be determined in the market place, provided such transfer of securities has been approved by the department in advance of the transfer, or

(iii) by a transfer of assets other than cash or securities having a value which can readily be determined in the market place if, in the opinion of the department, such transfer is not inequitable, provided such transfer of other assets has been approved by the department in advance of the transfer.

This provision shall not preclude or prohibit any of the following procedures:

(a) The exchange of securities in a segregated investment account may be made for cash from the general investment account of an insurance company, or the exchange of securities in such general investment account may be made for cash from a segregated investment account if

(i) the securities so exchanged have values which can readily be determined in the market place,

(ii) the exchange is made on the basis of the market values applicable to the securities at the time of the exchange, and

(iii) the consent of the department to such exchange has been obtained in advance.

(b) The sale of securities, for cash, from a segregated investment account and the purchase thereof, for cash, by an insurance company for its general investment account may be made in bona fide sale and purchase transactions involving one or more persons other than the insurance company and its officers or affiliates.

(c) The sale of securities, for cash, from the general investment account of an insurance company and the purchase thereof, for cash, for a segregated investment account of the company selling such securities may be made in bona fide sale and purchase transactions involving one or more persons other than the insurance company and its officers or affiliates.

(d) In respect of a Class I(c) contract providing that all or a portion of the segregated investment account is derived from a designated percentage of specific assets in the company's general investment portfolio, a change in said designated percentage may be made provided the change arises (i) by reason of the contractual withdrawals from or additions to such account or (ii) by reason of changes in said specific assets because of acquisitions or disposals.

(Department of Insurance; Reg 7,V; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 97; filed Mar 18, 1970, 10:20 am: Rules and Regs. 1971, p. 206; filed Apr 16, 1984, 3:53 pm: 7 IR 1518; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)

760 IAC 1-7-6 Valuation of separate account assets

Authority: IC 27-1-3-7
Affected: IC 27-1-5-1

Sec. 6. Valuation of Separate Account Assets. The valuation of all assets maintained in a segregated investment account devoted to Class I(c) Contracts shall be determined at the market value of such assets on the date of valuation, or if there is no readily available market, then in accordance with the terms of the Class I(c) Contract. *(Department of Insurance; Reg 7,VI; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 98; filed Mar 18, 1970, 10:20 am: Rules and Regs. 1971, p. 207; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-7-7 Foreign insurance companies

Authority: IC 27-1-3-7
Affected: IC 27-1-5-1

Sec. 7. Other Than Indiana Domestic Insurers. A life insurance company incorporated under the laws of any state or jurisdiction other than this state and authorized to do business in this state may be authorized to issue or deliver in this state Class I(c) Contracts only if authorized to issue such contracts under the laws of its domicile and the rules, regulations or other similar

promulgations of the Insurance Department or similar regulatory agency of its home state. *(Department of Insurance; Reg 7,VII; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 98; filed Mar 18, 1970, 10:20 am: Rules and Regs. 1971, p. 207; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-7-8 Variable annuity income benefits

Authority: IC 27-1-3-7
Affected: IC 27-1-5-1

Sec. 8. Variable Annuity Income Benefits. The following additional rules and regulations shall apply to any Class I(c) Contract which provides annuity income benefits, the amount of which may vary by reason of experience factors derived from a segregated investment account or accounts:

(a) In the case of any individual Class I(c) Contract, the mortality and investment increment factors used in computing the dollar amount of variable annuity income benefits or other contractual payments or values shall not produce a larger initial payment than would be produced by the use of the Annuity Mortality Table for 1949, Ultimate, and an annual investment increment assumption of 5%, except with the approval of the Department.

(b) Any Class I(c) Contract providing variable annuity income benefits may include a provision providing for stabilization of income through the use of an income stabilization reserve established pursuant to such provision.

(c) Any Class I(c) Contract providing variable annuity income benefits may contain a provision, applicable in the event of the surrender of such contract, for the payment of the value thereof over a period of time specified in the contract.

(d) Any individual Class I(c) Contract providing variable annuity income benefits delivered or issued for delivery in this state, and any certificate evidencing variable annuity income benefits under a Class I(c) Contract on a group basis, shall contain a statement of the essential features of the procedure to be followed by the insurance company in determining the dollar amount of annuity income benefits or other contractual payments or values thereunder and shall state in clear terms that such amount may decrease or increase according to such procedure. Each such contract and certificate shall contain on its first page, in a prominent position, a clear statement that the annuity income benefits or other contractual payments or values thereunder are on a basis which may vary according to the experience of assets in an account or accounts to which such individual or group contract is related.

(Department of Insurance; Reg 7,VIII; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 99; filed Mar 18, 1970, 10:20 am: Rules and Regs. 1971, p. 207; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)

Rule 8. Accident and Sickness Insurance – "Noncancellable" and "Guaranteed Renewable" Insurance Defined

760 IAC 1-8-1 Authority to promulgate rule; purpose of rule

Authority: IC 27-1-3-7
Affected: IC 27-8-5-1

Sec. 1. AUTHORITY AND PURPOSE. This regulation *[760 IAC 1-8]* is issued pursuant to the authority set forth in the Acts 1935, Chapter 162, Section 14 *[IC 27-1-3-7]* (Burns' Indiana Statutes, Section 39-3311 *[IC 27-1-3-7]*.). This regulation *[760 IAC 1-8]* concerns the adoption of definitions of "non-cancellable" and "guaranteed renewable" insurance as recommended by the National Association of Insurance Commissioners when such words or terms are used to describe the benefits and conditions of any accident and health policy issued for delivery in Indiana, and its purpose is for the conduct of the work of the Department of Insurance in accepting policy forms for file as provided by the Acts 1953, Chapter 15, Section 169.1 *[IC 27-8-5-1]* (Burns' Indiana Statutes, Section 39-4251 *[IC 27-8-5-1]*). *(Department of Insurance; Rule 8,I; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 100; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

760 IAC 1-8-2 "Non-cancellable" or "guaranteed renewable"; use of terms

Authority: IC 27-1-3-7
Affected: IC 27-8-5-3

Sec. 2. DEFINITIONS. (A) The terms "non-cancellable" or "non-cancellable and guaranteed renewable" may be used only

in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy (1) until at least age 50, or (2) in the case of a policy issued after age 44, for at least five years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

(B) Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums (1) until at least age 50, or (2) in the case of a policy issued after age 44, for at least five years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

(C) The foregoing limitation on use of the term "non-cancellable" shall also apply to any synonymous term such as "not cancellable" and the limitation on use of the term "guaranteed renewable" shall apply to any synonymous term such as "guaranteed continuable."

(D) Nothing herein contained is intended to restrict the development of policies having other guarantees of renewability, or to prevent the accurate description of their terms of renewability or the classification of such policies as guaranteed renewable or non-cancellable for any period during which they may actually be such, provided the terms used to describe them in policy contracts and advertising are not such as may readily be confused with the above terms. *(Department of Insurance; Rule 8,II; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 101; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 530)*

Rule 9. Accident and Sickness Insurance–Valuation of Individual Policies

760 IAC 1-9-1 Authority to promulgate rule; purpose of rule

Authority: IC 27-1-3-7
Affected: IC 27-8-5-1; IC 27-8-5-3

Sec. 1. AUTHORITY AND PURPOSE. This regulation *[760 IAC 1-9]* is issued pursuant to the authority set forth in the Acts 1935, Chapter 162, Section 14 *[IC 27-1-3-7]* (Burns' Indiana Statutes, Section 39-3911 *[IC 27-1-3-7]*). This regulation concerns the valuation of all individual accident and health insurance policies to place a sound value on the policy liabilities for the purpose of safeguarding the interests of policyholders, creditors, and shareholders. The valuation of individual accident and health policies set forth herein is on the bases recommended by the National Association of Insurance Commissioners (see: N.A.I.C. 1957 Proceedings-Volume I, page 77). *(Department of Insurance; Rule 9,I; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 102; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-9-2 Classification of individual policies

Authority: IC 27-1-3-7
Affected: IC 27-8-5-1; IC 27-8-5-3

Sec. 2. TYPES OF INDIVIDUAL ACCIDENT AND HEALTH INSURANCE POLICIES. (A) Policies which are guaranteed renewable for life or to a specified age, such as 60 or 65, at guaranteed premium rates.

(B) Policies which are guaranteed renewable for life or to a specified age, such as 60 or 65, but under which the insurer reserves the right to change the scale of premiums.

(C) Policies, other than those in Type D, in which the insurer has reserved the right to cancel or refuse renewal for one or more reasons, but has agreed implicitly or explicitly that, prior to a specified time or age, it will not cancel or decline renewal solely because of deterioration of health after issue.

(D) Franchise policies or certificates issued under or subject to an agreement that, except for stated reasons, the insurer will not cancel or refuse to renew the coverage of individual insureds prior to a specified age unless all coverage under the same group is terminated.

(E) Commercial policies and other policies not falling within Types A to D, inclusive. *(Department of Insurance; Rule 9,II; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 102; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-9-3 Valuation standards

Authority: IC 27-1-3-7
Affected: IC 27-8-5-1; IC 27-8-5-3

Sec. 3. STANDARDS OF VALUATION. (a) Standards of valuation for policies issued January 1, 1952 to December 31, 1963. The minimum reserves on all "non-cancellable, guaranteed-renewable, fixed- or level-premium accident and health policies" issued from January 1, 1952 to December 31, 1963, inclusive, shall be continued on the same basis as prescribed by the Indiana Department of Insurance ruling dated November 19, 1951.

(b) Standards of valuation for policies of Type A, B, or C listed under II. During the period within which the renewability of the policy is guaranteed or the insurer's right to refuse renewal is limited, the minimum reserve for policies of Type A, B or C issued on or after January 1, 1964 shall be an amount computed on the basis of two-year preliminary term tabular mean reserves employing the following assumptions:

Mortality: 1958 Commissioners Standard Ordinary Table or 1941 Commissioners Standard Ordinary Table or American Men Ultimate Table.

Maximum Interest Rate–3 1/2% compounded annually

Morbidity or other Contingency:

Disability due to accident and sickness–Conference Modification of Class III Disability Table.

Hospital Expense Benefits –1956 Inter-company Hospital Table.

Surgical Expense Benefits –1956 Inter-company Surgical Table.

For accident only, major medical expense, and other benefits not specified above, each company is required to establish reserves that place a sound value on the liabilities under such benefit.

Such mean reserves shall be diminished or offset by appropriate credit for the valuation net deferred premiums. In no event, however, shall the aggregate reserves for all policies issued on or after January 1, 1964 and valued on the mean reserve basis, diminished by any credit for deferred premiums, be less than the gross pro rata unearned premiums under such policies.

Negative Reserves. The negative reserves on any benefit may be offset against positive reserves for other benefits in the same individual or family policy, but if all benefits of such policy collectively develop a negative reserve, credit shall not be taken for such amount.

(c) Standard of valuation for policies of Type D or E listed under II. For policies of Type D or E, the minimum reserve shall be the pro rata gross unearned premium.

(d) Alternative valuation procedures and assumptions. Provided the reserve on all policies to which the method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified above, an insurer may use any reasonable assumptions as to the interest rate, mortality rates, or the rates of morbidity or other contingency, and may introduce an assumption as to the voluntary termination of policies. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under such policies, including but not limited to the following: (i) the use of mid-terminal reserves in addition to either gross or net pro rata unearned premium reserves; (ii) optional use of either the level premium, the one-year preliminary term, or the two-year preliminary term method; (iii) prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses; (iv) the use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity; (v) the computation of the reserve for one policy benefit as a percentage of, or by other relation to, the aggregate policy reserves, exclusive of the benefit or benefits so valued; (vi) the use of a composite annual claim cost for all or any combination of the benefits included in the policies valued.

For statement purposes the net reserve liability for active lives may be shown as (i) the mean reserve with offsetting asset items for net unpaid and deferred premiums, (ii) the excess of the mean reserve over the amount of net unpaid and deferred premiums, or (iii) it may, regardless of the underlying method of calculation, be divided between the gross pro rata unearned premium reserve and a balancing item for the "additional reserve." *(Department of Insurance; Rule 9,III; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 103; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-9-4 National Association of Insurance Commissioners recommendations incorporated by reference

Authority: IC 27-1-3-7
Affected: IC 27-8-5-1; IC 27-8-5-3

Sec. 4. REFERENCE TO "COMMENT AND EXPLANATION" MATERIAL. The substance of the "Comment and Explanation" material relating to the National Association of Insurance Commissioners recommendations (see: N.A.I.C. 1957

Proceedings–Volume I, page 80) is incorporated by reference and made a part of this regulation *[760 IAC 1-9]*. *(Department of Insurance; Rule 9,IV; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 104; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 10. Life, Accident and Sickness Insurance–Assessment Plan Insurance Policies

760 IAC 1-10-1 Authority to promulgate rule; purpose of rule

Authority: IC 27-1-3-7
Affected: IC 27-1-2-3; IC 27-1-12-13; IC 27-8-5-1

Sec. 1. AUTHORITY AND PURPOSES. This regulation is issued pursuant to the authority set forth in the Acts 1935, Chapter 162, Section 14 *[IC 27-1-3-7]* (Burns' Indiana Statutes, Section 39-3311 *[IC 27-1-3-7]*). This regulation *[760 IAC 1-10]* concerns the prominent disclosure and description of the "assessment plan" or "assessment insurance" feature of life and/or accident and/or health insurance policies which are issued on the "assessment plan" or "assessment insurance" basis and its purpose is for the conduct of the work of the Department in accepting policy forms for file as provided by the Acts 1935, Chapter 162, Section 154 *[IC 27-1-12-13]* (Burns' Indiana Statutes, Section 39-4209 *[IC 27-1-12-13]*) and the Acts 1953, Chapter 15, Section 169.1 *[IC 27-8-5-1]* (Burns' Indiana Statutes, Section 39-4251 *[IC 27-8-5-1]*) and for the purpose of safeguarding the interests of policyholders. The terms "assessment plan" and "assessment insurance" are defined in the Acts of 1935, Chapter 162, Section 3 *[IC 27-1-2-3(y)]* (Burns' Indiana Statutes, Section 39-3203 *(y)[IC 27-1-2-3(y)]*). *(Department of Insurance; Rule 10,I; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 105; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-10-2 Policy statements

Authority: IC 27-1-3-7
Affected: IC 27-1-2-3; IC 27-8-5-1

Sec. 2. REQUIRED PROVISIONS. No policy of life and/or accident and/or health insurance which is "assessment insurance" or is issued on the "assessment plan" basis bearing a date of issue which is the same as or later than July 1, 1964, shall be delivered or issued for delivery in Indiana, unless the same shall provide the following:

(1) A title on the face and on the back of the policy describing that such insurance is "assessment insurance" or is issued on the "assessment plan" basis; and

(2) A separate provision on the face of the policy describing "assessment insurance" or "assessment plan" insurance.

(Department of Insurance; Rule 10,II; filed Feb 3, 1964, 9:40 am: Rules and Regs. 1965, p. 106; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 11. Domestic Stock Insurance Companies–Proxies, and Consents and Authorizations

760 IAC 1-11-1 Authority to promulgate rule; purpose of rule

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 1. Authority and Purpose. This regulation *[760 IAC 1-11]* is issued pursuant to the authority set forth in the Indiana Insurance Law, Acts of the Indiana General Assembly of 1935, Chapter 162, Page 588, Section 14 *[IC 27-1-3-7]* as amended by Acts of the Indiana General Assembly of 1965, Chapter 178, Section 1 *[IC 27-1-3-7]* (Burns Indiana Statutes, Section 39-3311 *[IC 27-1-3-7]*).

The purpose of the *regulation[760 IAC 1-11]* is to govern the method of soliciting proxies, consents and authorizations by certain domestic stock insurance companies, and to prescribe the form of such proxies, consents and authorizations, and to assure that security holders of such companies be provided with certain information concerning such companies when proxies, consents and authorizations are solicited. This regulation *[760 IAC 1-11]* is in accordance with regulations recommended to the several states for adoption by the National Association of Insurance Commissioners. *(Department of Insurance; Reg 11,Sec 1; filed Apr 29, 1966, 11:50 am: Rules and Regs. 1967, p. 87; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 186; readopted filed Sep 14, 2001,*

12:22 p.m.: 25 IR 531)

760 IAC 1-11-2 Applicability of rule
Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 2. Application of Regulation. This regulation *[760 IAC 1-11]* is applicable to each domestic stock insurer which has any class of equity security held of record by one hundred or more persons entitled to vote; provided, however, that this regulation shall not apply to any insurer if ninety-five per cent or more of its equity securities are owned or controlled by a parent or an affiliated insurer and the remaining securities are held of record by less than five hundred persons. A domestic stock insurer which files with the Securities and Exchange Commission forms of proxies, consents and authorizations complying with the requirements of the Securities Exchange Act of 1934, as amended, and the applicable regulations promulgated thereunder, shall be exempt from the provisions of this regulation with respect to any class of securities subject to SEC jurisdiction. *(Department of Insurance; Reg 11,Sec 2; filed Apr 29, 1966, 11:50 am: Rules and Regs. 1967, p. 87; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 186; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-11-3 Solicitation of proxies, consents, and authorizations
Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 3. Proxies, Consents and Authorizations. No domestic stock insurer, or any director, officer or employee of such insurer subject to section one *[760 IAC 1-11-2]* hereof, or any other person, shall solicit, or permit the use of his name to solicit by mail or otherwise, any proxy, consent or authorization in respect of any class of equity security of such insurer held of record by one hundred or more persons in contravention of this regulation and Schedules A and B *[760 IAC 1-11-12 and 760 IAC 1-11-13]* hereto annexed and hereby made a part of this regulation *[760 IAC 1-11]*. *(Department of Insurance; Reg 11,Sec 3; filed Apr 29, 1966, 11:50 am: Rules and Regs. 1967, p. 87; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 186; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-11-4 Disclosure of equivalent information when solicitation not made
Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 4. Disclosure of Equivalent Information. Unless proxies, consents or authorizations in respect of any class of equity security of a domestic insurer subject to section one *[760 IAC 1-11-2]* hereof are solicited by or on behalf of the management of such insurer from the holders of record of such security in accordance with this regulation *[760 IAC 1-11]* and the Schedules hereunder prior to any annual or other meeting of such security holders, such insurer shall, in accordance with this regulation and such further regulations as the Commissioner may adopt, file with the Commissioner and transmit to all security holders of record information substantially equivalent to the information which would be required to be transmitted if a solicitation were made. Such insurer shall transmit a written information statement containing the information specified in subsection 4 of section 5 *[760 IAC 1-11-6(4)]* to every security holder who is entitled to vote in regard to any matter to be acted upon at the meeting and from whom a proxy is not solicited on behalf of the management of the insurer; provided, that in the case of a class of securities in unregistered or bearer form such statement need not be transmitted only to those security holders whose names and addresses are known to the insurer. *(Department of Insurance; Reg 11,Sec 4; filed Apr 29, 1966, 11:50 am: Rules and Regs. 1967, p. 87; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 187; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-11-5 Definitions
Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 5. Definitions. (1) The definitions and instructions set out in schedule SIS, as promulgated by the National Association

of Insurance Commissioners, shall be applicable for purposes of this regulation *[760 IAC 1-11]*.

(2) The terms "solicit" and "solicitation" for purposes of this regulation *[760 IAC 1-11]* shall include:

(a) any request for proxy, whether or not accompanied by or included in a form of proxy; or

(b) any request to execute or not to execute, or to revoke a proxy; or

(c) the furnishing of a form of proxy or other communication to security holders under circumstances reasonably calculated to result in the procurement, withholding or revocation of a proxy.

(3) The terms "solicit" and "solicitation" shall not include:

(a) any solicitation by a person in respect of securities of which he is the beneficial owner;

(b) action by a broker or other person in respect to securities carried in his name or in the name of his nominee in forwarding to the beneficial owner of such securities soliciting material received from the insurer, or impartially instructing such beneficial owner to forward a proxy to the person, if any, to whom the beneficial owner desires to give a proxy, or impartially requesting instructions from the beneficial owner with respect to the authority to be conferred by the proxy and stating that a proxy will be given if the instructions are received by a certain date;

(c) the furnishing of a form of proxy to a security holder upon the unsolicited request of such security holder, or the performance by any person of ministerial acts on behalf of a person soliciting a proxy.

(Department of Insurance; Reg 11,Sec 5; filed Apr 29, 1966, 11:50 am: Rules and Regs. 1967, p. 88; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 187; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-11-6 Disclosure to security holders

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 6. Information to be Furnished to Security Holders. (1) No solicitation subject to this regulation *[760 IAC 1-11]* shall be made unless each person solicited is concurrently furnished or has previously been furnished with a written proxy statement containing the information specified in Schedule A *[760 IAC 1-11-12]*.

(2) If the solicitation is made on behalf of the management of the insurer and relates to an annual meeting of security holders at which directors are to be elected, each proxy statement furnished pursuant to subsection one hereof shall be accompanied or preceded by an annual report (in preliminary or final form) to such security holders containing such financial statements for the last fiscal year as are referred to in Schedule SIS under the heading "Financial Reporting to Stockholders." Subject to the foregoing requirements with respect to financial statements, the annual report to security holders may be in any form deemed suitable by the management.

(3) Two copies of each report sent to the security holders pursuant to this section shall be mailed to the Commissioner not later than the date on which such report is first sent or given to security holders or the date on which preliminary copies of solicitation material are filed with the Commissioner pursuant to subsection one of section seven *[760 IAC 1-11-8(1)]*, whichever date is later.

(4) If no solicitation is being made by management of the insurer with respect to any annual or other meeting, such insurer shall mail to every security holder of record at least twenty days prior to the meeting date, an information statement as required by section 3 *[760 IAC 1-11-4]*, containing the information called for by all of the Items of Schedule A *[760 IAC 1-11-12]*, other than Items 1, 3 and 4 thereof, which would be applicable to any matter to be acted upon at the meeting if proxies were to be solicited in connection with the meeting. If such information statement relates to an annual meeting at which directors are to be elected, it shall be accompanied by an annual report to such security holders in the form provided in subsection 2 hereof. *(Department of Insurance; Reg 11,Sec 6; filed Apr 29, 1966, 11:50 am: Rules and Regs. 1967, p. 88; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 188; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-11-7 Proxy and information statements; form; effect

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 7. Requirements as to Proxy and Information Statement. (1) The form of proxy (a) shall indicate in bold-face type whether or not the proxy is solicited on behalf of the management, (b) shall provide a specifically designated blank space for dating the

proxy, and (c) shall identify clearly and impartially each matter or group of related matters intended to be acted upon, whether proposed by the management, or security holders. No reference need be made to proposals as to which discretionary authority is conferred pursuant to subsection three hereof.

(2) (a) Means shall be provided in such proxy for the person solicited to specify by ballot a choice between approval or disapproval of each matter or group of related matters referred to therein, other than elections to office. A proxy may confer discretionary authority with respect to matters as to which a choice is not so specified if the form of proxy states in bold-face type how it is intended to vote the shares or authorization represented by the proxy in each such case.

(b) A form of proxy which provides both for elections to office and for action on other specified matters shall be prepared so as to clearly provide, by a box or otherwise, means by which the security holder may withhold authority to vote for elections to office. Any such form of proxy which is executed by the security holder in such manner as not to withhold authority to vote for elections to office shall be deemed to grant such authority, provided the form of proxy so states in bold-face type.

(3) Such proxy may confer discretionary authority with respect to other matters which may come before the meeting, provided the persons on whose behalf the solicitation is made are not aware a reasonable time prior to the time the solicitation is made that any other matters are to be presented for action at the meeting and provided further that a specific statement to that effect is made in the proxy statement or in the form of proxy.

(4) No such proxy shall confer authority (a) to vote for the election of any person to any office for which a bona fide nominee is not named in the proxy statement, or (b) to vote at any annual meeting other than the next annual meeting (or any adjournment thereof) to be held after the date on which the proxy statement and form of proxy are first sent or given to security holders.

(5) Such proxy statement or form of proxy shall provide, subject to reasonable specified conditions, that such proxy will be voted and that where the person solicited specifies by means of ballot provided pursuant to subsection two *[760 IAC 1-11-7(2)]* hereof a choice with respect to any matter to be acted upon, the vote will be in accordance with the specifications so made.

(6) The information included in the proxy statement or information statement shall be clearly presented and the statements made shall be divided into groups according to subject matter, with appropriate headings. All printed proxy statements or information statements shall be clearly and legibly presented. *(Department of Insurance; Reg 11,Sec 7; filed Apr 29, 1966, 11:50 am: Rules and Regs. 1967, p. 89; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 188; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-11-8 Filing requirements

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 8. Material Required to be Filed. (1) Two preliminary copies of the information statement or the proxy statement and form of proxy and any other soliciting material to be furnished to security holders concurrently therewith shall be filed with the Commissioner at least ten days prior to the date definitive copies of such material are first sent or given to security holders, or such shorter period prior to that date as the Commissioner may authorize upon a showing of good cause therefor.

(2) Two preliminary copies of any additional soliciting material relating to the same meeting or subject matter to be furnished to security holders subsequent to the proxy statements shall be filed with the Commissioner at least two days (exclusive of Saturdays, Sundays or holidays) prior to the date copies of this material are first sent or given to security holders or a shorter period prior to such date as the Commissioner may authorize upon a showing of good cause therefor.

(3) Two definitive copies of the information statement or the proxy statement, form of proxy and all other soliciting material, in the form in which this material is furnished to security holders, shall be filed with, or mailed for filing to, the Commissioner not later than the date such material is first sent or given to the security holders.

(4) Where any information statement or proxy statement, form of proxy or other material filed pursuant to this regulation *[760 IAC 1-11]* is amended or revised, two of the copies shall be marked to clearly show such changes.

(5) Copies of replies to inquiries from security holders requesting further information and copies of communications which do no more than request that forms or proxy theretofore solicited be signed and returned need not be filed pursuant to this section.

(6) Notwithstanding the provisions of subsections one and two *[760 IAC 1-11-8(1) and (2)]* hereof and of subsection five of section ten *[760 IAC 1-11-11(5)]*, copies of soliciting material in the form of speeches, press releases and radio or television scripts may, but need not, be filed with the Commissioner prior to use or publication. Definitive copies, however, shall be filed with or mailed for filing to the Commissioner as required by subsection three hereof not later than the date such material is used or published. The provisions of subsections one and two *[760 IAC 1-11-8(1) and (2)]* hereof and subsection five of section ten *[760*

IAC 1-11-11(5)] shall apply, however, to any reprints or reproductions of all or any part of such material. *(Department of Insurance; Reg 11,Sec 8; filed Apr 29, 1966, 11:50 am: Rules and Regs. 1967, p. 90; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 189; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-11-9 False or misleading statements prohibited

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 9. False or Misleading Statements. No proxy statement, form of proxy, notice of meeting, information statement, or other communication, written or oral, subject to this regulation, shall contain any statement which at the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact, or which omits to state any material fact necessary in order to make the statements therein not false or misleading or necessary to correct any statement in any earlier communication with respect to the same meeting or subject matter which has become false or misleading. *(Department of Insurance; Reg 11,Sec 9; filed Apr 29, 1966, 11:50 am: Rules and Regs. 1967, p. 90; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 190; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-11-10 Solicitation of undated or postdated proxies prohibited

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 10. Prohibition of Certain Solicitations. No person making a solicitation which is subject to this regulation *[760 IAC 1-11]* shall solicit any undated or postdated proxy or any proxy which provides that it shall be deemed to be dated as of any date subsequent to the date on which it is signed by the security holder. *(Department of Insurance; Reg 11,Sec 10; filed Apr 29, 1966, 11:50 am: Rules and Regs. 1967, p. 91; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 190; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-11-11 Election contests

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 11. Special Provisions Applicable to Election Contests. (1) Applicability. This section shall apply to any solicitation subject to this regulation *[760 IAC 1-11]* by any person or group for the purpose of opposing a solicitation subject to this regulation by any other person or group with respect to the election or removal of directors at any annual or special meeting of security holders.

(2) Participant or Participant in a Solicitation.

(a) For purposes of this section the term "participant" and "participant in a solicitation" include: (i) the insurer; (ii) any director of the insurer, and any nominee for whose election as a director proxies are solicited; (iii) any other person, acting alone or with one or more other persons, committees or groups, in organizing, directing or financing the solicitation.

(b) For the purposes of this section the terms "participant" and "participant in a solicitation" do not include: (i) a bank, broker or dealer who, in the ordinary course of business, lends money or executes orders for the purchase or sale of securities and who is not otherwise a participant; (ii) any person or organization retained or employed by a participant to solicit security holders or any person who merely transmits proxy soliciting material or performs ministerial or clerical duties; (iii) any person employed in the capacity of attorney, accountant, or advertising, public relations or financial adviser, and whose activities are limited to the performance of his duties in the course of such employment; (iv) any person regularly employed as an officer or employee of the insurer or any of its subsidiaries or affiliates who is not otherwise a participant; or (v) any officer or director of, or any person regularly employed by any other participant, if such officer, director, or employee is not otherwise a participant.

(3) Filing of Information Required by Schedule B *[760 IAC 1-11-13]*.

(a) No solicitation subject to this section shall be made by any person other than the management of an insurer unless at least five business days prior thereto, or such shorter period as the Commissioner may authorize upon a showing of good cause therefor, there has been filed, with the Commissioner by or on behalf of each participant in such solicitation, a statement in

duplicate containing the information specified by Schedule B *[760 IAC 1-11-13]* and a copy of any material proposed to be distributed to security holders in furtherance of such solicitation. Where preliminary copies of any materials are filed, distribution to security holders should be deferred until the Commissioner's comments have been received and complied with.

(b) Within five business days after a solicitation subject to this section is made by the management of an insurer, or such longer period as the Commissioner may authorize upon a showing of good cause therefor, there shall be filed with the Commissioner by or on behalf of each participant in such solicitation, other than the insurer, and by or on behalf of each management nominee for director, a statement in duplicate containing the information specified by Schedule B *[760 IAC 1-11-13]*.

(c) If any solicitation on behalf of management or any other person has been made, or if proxy material is ready for distribution, prior to a solicitation subject to this section in opposition thereto, a statement in duplicate containing the information specified in Schedule B *[760 IAC 1-11-13]* shall be filed with the Commissioner, by or on behalf of each participant in such prior solicitation, other than the insurer, as soon as reasonably practicable after the commencement of the solicitation in opposition thereto.

(d) If, subsequent to the filing of the statements required by paragraphs (a), (b) and (c) of this subsection, additional persons become participants in a solicitation subject to this section, there shall be filed with the Commissioner, by or on behalf of each such person, a statement in duplicate containing the information specified by Schedule B *[760 IAC 1-11-13]*, within three business days after such person becomes a participant, or such longer period as the Commissioner may authorize upon a showing of good cause therefor.

(e) If any material change occurs in the facts reported in any statement filed by or on behalf of any participant, an appropriate amendment to such statement shall be filed promptly with the Commissioner.

(f) Each statement and amendment thereto filed pursuant to this paragraph shall be part of the public files of the Commissioner.

(4) Solicitations Prior to Furnishing Required Written Proxy Statement.

Notwithstanding the provisions of subsection one of section five, a solicitation subject to this section may be made prior to furnishing security holders a written proxy statement containing the information specified in Schedule A *[760 IAC 1-11-12]* with respect to such solicitation, provided that:

(a) The statements required by subsection three hereof are filed by or on behalf of each participant in such solicitation.

(b) No form of proxy is furnished to security holders prior to the time the written proxy statement required by subsection one of section five is furnished to such persons: Provided, however, that this paragraph (b) shall not apply where a proxy statement then meeting the requirements of Schedule A *[760 IAC 1-11-12]* has been furnished to security holders.

(c) At least the information specified in paragraphs (b) and (c) of the statements required by subsection three hereof to be filed by each participant, or an appropriate summary thereof, are included in each communication sent or given to security holders in connection with the solicitation.

(d) A written proxy statement containing the information specified in Schedule A *[760 IAC 1-11-12]* with respect to a solicitation is sent or given security holders at the earliest practicable date.

(5) Solicitations Prior to Furnishing Required Written Proxy Statement – Filing Requirements.

Two copies of any soliciting material proposed to be sent or given to security holders prior to the furnishing of the written proxy statement required by subsection one of section five shall be filed with the Commissioner in preliminary form at least five business days prior to the date definitive copies of such material are first sent or given to such persons, or such shorter period as the Commissioner may authorize upon a showing of good cause therefor.

(6) Application of this Section to Annual Report.

Notwithstanding the provisions of subsections two and three of section five, two copies of any portion of the annual report referred to in subsection two of section five *[760 IAC 1-11-6(2)]* which comments upon or refers to any solicitation subject to this section, or to any participant in any such solicitation, other than the solicitation by the management, shall be filed with the Commissioner, as proxy material subject to this regulation *[760 IAC 1-11]*. Such portion of the report shall be filed with the Commissioner, in preliminary form, at least five business days prior to the date copies of the report are first sent or given to security holders. *(Department of Insurance; Reg 11,Sec 11; filed Apr 29, 1966, 11:50 am: Rules and Regs. 1967, p. 91; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 191; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-11-12 Schedule A; information required in proxy statement or information statement

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 12. SCHEDULE A – INFORMATION REQUIRED IN PROXY STATEMENT OR INFORMATION STATEMENT. Item 1. Revocability of Proxy. State whether or not the person giving the proxy has the power to revoke it. If the right of revocation before the proxy is exercised is limited or is subject to compliance with any formal procedure, briefly describe such limitation or procedure.

Item 2. Dissenters' Rights of Appraisal. Outline briefly the rights of appraisal or similar rights of dissenting security holders with respect to any matter to be acted upon and indicate any statutory procedure required to be followed by such security holders in order to perfect their rights. Where such rights may be exercised only within a limited time after the date of the adoption of a proposal, the filing of Articles of Incorporation amendment, or other similar act, state whether the person solicited will be notified of such date.

Item 3. Persons Making Solicitations Not Subject to Section 10 *[760 IAC 1-11-11]*.

(1) If the solicitation is made by the management of the insurer, so state. Give the name of any director of the insurer who has informed the management in writing that he intends to oppose any action intended to be taken by the management and indicate the action which he intends to oppose.

(2) If the solicitation is made otherwise than by the management of the insurer, state the names and addresses of the persons by whom and on whose behalf it is made and the names and addresses of the persons by whom the cost of solicitation has been or will be borne, directly or indirectly.

(3) If the solicitation is to be made by specially engaged employees or paid solicitors, state (i) the material features of any contract or arrangement for such solicitation and identify the parties, and (ii) the cost or anticipated cost thereof.

Item 4. Interest of Certain Persons in Matters to be Acted Upon. Describe briefly any substantial interest, direct or indirect, by security holdings or otherwise, of any director, nominee for election as director, officer and, if the solicitation is made otherwise than on behalf of management, each person on whose behalf the solicitation is made, in any matter to be acted upon, other than elections to office.

Item 5. Voting Securities.

(1) State, as to each class of voting securities of the insurer entitled to be voted at the meeting, the number of shares outstanding and the number of votes to which each class is entitled.

(2) Give the date as of which the record list of security holders entitled to vote at the meeting will be determined. If the right to vote is not limited to security holders of record on that date, indicate the conditions under which other security holders may be entitled to vote.

(3) If action is to be taken with respect to the election of directors and if the persons solicited have cumulative voting rights, make a statement that they have such rights and state briefly the conditions precedent to the exercise thereof.

Item 6. Nominees and Directors.

If action is to be taken with respect to the election of directors furnish the following information, in tabular form to the extent practicable, with respect to each person nominated for election as a director and each other person whose term of office as a director will continue after the meeting:

(a) Name each such person, state when his term of office or the term of office for which he is a nominee will expire, and all other positions and offices with the insurer presently held by him, and indicate which persons are nominees for election as directors at the meeting.

(b) State his present principal occupation or employment and give the name and principal business of any corporation or other organization in which such employment is carried on. Furnish similar information as to all of his principal occupations or employments during the last five years, unless he is now a director and was elected to his present term of office by vote of security holders at a meeting for which proxies were solicited under this regulation *[760 IAC 1-11]*.

(c) If he is or has previously been a director of the insurer, state the period or periods during which he has served as such.

(d) State, as of the most recent practicable date, the approximate amount of each class of equity securities of the insurer or any of its parents, subsidiaries or affiliates other than directors' qualifying shares, beneficially owned directly or indirectly by him. If he is not the beneficial owner of any such securities, make a statement to that effect.

Item 7. Remuneration and Other Transactions with Management and Others.

Furnish the information reported or required in Item One of Schedule SIS under the heading "Information Regarding Management and Directors" if action is to be taken with respect to (a) the election of directors, (b) any remuneration plan, contract or arrangement in which any director, nominee for election as a director, or officer of the insurer will participate, (c) any pension or retirement plan in which any such person will participate, or (d) the granting or extension to any such person of any options, warrants or rights to purchase any securities, other than warrants or rights issued to security holders, as such, on a pro rata basis. If the solicitation is made on behalf of persons other than the management, information shall be furnished only as to Item One-A of the aforesaid heading of Schedule SIS.

Item 8. Bonus, Profit Sharing and Other Remuneration Plans.

If action is to be taken with respect to any bonus, profit sharing, or other remuneration plan, of the insurer, furnish the following information:

(a) A brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation.

(b) The amounts which would have been distributable under the plan during the last calendar year to (1) each person named in item seven of this schedule, (2) directors and officers as a group, and (3) all other employees as a group, if the plan had been in effect.

(c) If the plan to be acted upon may be amended (other than by a vote of security holders) in a manner which would materially increase the cost thereof to the insurer or to materially alter the allocation of the benefits as between the groups specified in paragraph (b) of this item, the nature of such amendments should be specified.

Item 9. Pension and Retirement Plans.

If action is to be taken with respect to any pension or retirement plan of the insurer, furnish the following information:

(a) A brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation.

(b) State (1) the approximate total amount necessary to fund the plan with respect to past services, the period over which such amount is to be paid, and the estimated annual payments necessary to pay the total amount over such period; (2) the estimated annual payment to be made with respect to current services; and (3) the amount of such annual payment to be made for the benefit of (i) each person named in item seven of this schedule, (ii) directors and officers as a group and (iii) employees as a group.

(c) If the plan to be acted upon may be amended (other than by a vote of security holders) in a manner which would materially increase the cost thereof to the insurer or to materially alter the allocation of the benefits as between the groups specified in sub-paragraph (b) (3) of this item, the nature of such amendments should be specified.

Item 10. Options, Warrants, or Rights.

If action is to be taken with respect to the granting or extension of any options, warrants or rights (all referred to herein as "warrants") to purchase securities of the insurer or any subsidiary or affiliate, other than warrants issued to all security holders on a pro rata basis, furnish the following information:

(a) The title and amount of securities called for or to be called for, the prices, expiration dates and other material conditions upon which the warrants may be exercised, the consideration received or to be received by the insurer, subsidiary or affiliate for the granting or extension of the warrants and the market value of the securities called for or to be called for by the warrants, as of the latest practicable date.

(b) If known, state separately the total amount of securities called for by warrants received or to be received by the following persons, naming each such person: (1) each person named in item seven of this schedule, and (2) each other person who will be entitled to acquire five per cent or more of the securities called for or to be called for by such warrants.

(c) If known, state also the total amount of securities called for or to be called for by such warrants, received or to be received by all directors and officers of the company as a group and all employees, without naming them.

Item 11. Authorization or Issuance of Securities.

(1) If action is to be taken with respect to the authorization or issuance of any securities of the insurer furnish the title, amount and description of the securities to be authorized or issued.

(2) If the securities are other than additional shares of common stock of a class outstanding, furnish a brief summary of the following, if applicable: dividend, voting, liquidation, preemptive, and conversion rights, redemption and sinking fund provisions, interest rate and date of maturity.

(3) If the securities to be authorized or issued are other than additional shares of common stock of a class outstanding, the

Commissioner may require financial statements comparable to those contained in the annual report.

Item 12. Mergers, Consolidations, Acquisitions and Similar Matters.

(1) If action is to be taken with respect to a merger, consolidation, acquisition, or similar matter, furnish in brief outline the following information:

(a) The rights of appraisal or similar rights of dissenters with respect to any matters to be acted upon. Indicate any procedure required to be followed by dissenting security holders in order to perfect such rights.

(b) The material features of the plan or agreement.

(c) The business done by the company to be acquired or whose assets are being acquired.

(d) If available, the high and low sales prices for each quarterly period within two years.

(e) The percentage of outstanding shares which must approve the transaction before it is consummated.

(2) For each company involved in a merger, consolidation or acquisition, the following financial statements should be furnished:

(a) A comparative balance sheet as of the close of the last two fiscal years.

(b) A comparative statement of operating income and expenses for each of the last two fiscal years and, as a continuation of each statement, a statement of earnings per share after related taxes and cash dividends paid per share.

(c) A pro forma combined balance sheet and income and expenses statement for the last fiscal year giving effect to the necessary adjustments with respect to the resulting company.

Item 13. Restatement of Accounts.

If action is to be taken with respect to the restatement of an asset, capital, or surplus account of the insurer, furnish the following information:

(a) State the nature of the restatement and the date as of which it is to be effective.

(b) Outline briefly the reasons for the restatement and for the selection of the particular effective date.

(c) State the name and amount of each account affected by the restatement and the effect of the restatement thereon.

Item 14. Matters Not Required to be Submitted.

If action is to be taken with respect to any matter which is not required to be submitted to a vote of security holders, state the nature of such matter, the reason for submitting it to a vote of security holders and what action is intended to be taken by the management in the event of a negative vote on the matter by the security holders.

Item 15. Amendment of Charter, By-Laws, or Other Documents.

If action is to be taken with respect to any amendment of the insurer's charter, by-laws or other documents as to which information is not required above, state briefly the reasons for and general effect of such amendment and the vote needed for its approval. *(Department of Insurance; Reg 11,Schedule A; filed Apr 29, 1966, 11:50 am: Rules and Regs. 1967, p. 93; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 193; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-11-13 Schedule 13; information required in statements of proxy solicitation in an election contest

Authority: IC 27-1-3-7

Affected: IC 27-1-3-7

Sec. 13. SCHEDULE B–INFORMATION TO BE INCLUDED IN STATEMENTS FILED BY OR ON BEHALF OF A PARTICIPANT (OTHER THAN THE INSURER) IN A PROXY SOLICITATION IN AN ELECTION CONTEST. Item 1. Insurer. State the name and address of the insurer.

Item 2. Identity and Background.

(a) State the following:

(1) Your name and business address.

(2) Your present principal occupation or employment and the name, principal business and address of any corporation or other organization in which such employment is carried on.

(b) State the following:

(1) Your residence address.

(2) Information as to all material occupations, positions, offices or employments during the last ten years, giving starting and ending dates of each and the name, principal business and address of any business corporation or other business organization in which each such occupation, position, office or employment was carried on.

(c) State whether or not you are or have been a participant in any other proxy contest involving this company or other companies within the past ten years. If so, identify the principals, the subject matter and your relationship to the parties and the outcome.
(d) State whether or not, during the past ten years, you have been convicted in a criminal proceeding (excluding traffic violations or similar misdemeanors) and, if so, give dates, nature of conviction, name and location of court, and penalty imposed or other disposition of the case. A negative answer to this sub-item need not be included in the proxy statement or other proxy soliciting material.
Item 3. Interest in Securities of the Insurer.
(a) State the amount of each class of securities of the insurer which you own beneficially, directly or indirectly.
(b) State the amount of each class of securities of the insurer which you own of record but not beneficially.
(c) State with respect to all securities of the insurer purchased or sold within the past two years, the dates on which they were purchased or sold and the amount purchased or sold on each such date.
(d) If any part of the purchase price or market value of any of the securities specified in paragraph (c) is represented by funds borrowed or otherwise obtained for the purpose of acquiring or holding such securities, so state and indicate the amount of the indebtedness as of the last practicable date. If such funds were borrowed or obtained otherwise than pursuant to a margin account or bank loan in the regular course of business of a bank, broker or dealer, briefly describe the transaction, and state the names of the parties.
(e) State whether or not you are a party to any contracts, arrangements or understandings with any person with respect to any securities of the insurer, including but not limited to joint ventures, loan or option arrangements, puts or calls, guarantees against losses or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. If so, name the persons with whom such contracts, arrangements, or understandings exist and give the details thereof.
(f) State the amount of securities of the insurer owned beneficially, directly or indirectly, by each of your associates and the name and address of each such associate.
(g) State the amount of each class of securities of any parent, subsidiary or affiliate of the insurer which you own beneficially, directly or indirectly.
Item 4. Further Matters.
(a) Describe the time and circumstances under which you became a participant in the solicitation and state the nature and extent of your activities or proposed activities as a participant.
(b) Describe briefly, and where practicable state the approximate amount of, any material interest, direct or indirect, of yourself and of each of your associates in any material transactions since the beginning of the company's last fiscal year, or in any material proposed transactions, to which the company or any of its subsidiaries or affiliates was or is to be a party.
(c) State whether or not you or any of your associates have any arrangement or understanding with any person–

(1) with respect to any future employment by the insurer or its subsidiaries or affiliates; or

(2) with respect to any future transactions to which the insurer or any of its subsidiaries or affiliates will or may be a party.

If so, describe such arrangement or understanding and state the names of the parties thereto.
Item 5. Signature.
The statement shall be dated and signed in the following manner:
I certify that the statements made in this statement are true, complete, and correct, to the best of my knowledge and belief.

_____ _____

(date) Signature of participant or authorized representative

(Department of Insurance; Reg 11, Schedule B; filed Apr 29, 1966, 11:50 am: Rules and Regs. 1967, p. 97; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 198; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 12. Domestic Stock Insurance Companies–Insider Trading of Equity Securities

760 IAC 1-12-1 Authority to promulgate rule; purpose of rule

Authority: IC 27-1-3-7
Affected: IC 27-2-10-8

Sec. 1. Authority and Purpose. This regulation *[760 IAC 1-12]* is promulgated pursuant to the authority vested in the Indiana Insurance Commissioner by Section 8 *[IC 27-2-10-8]* of the Acts of 1965, Chapter 5 entitled "An Act Concerning Securities of Indiana Companies," (Section 39-3734, Burns Indiana Statutes Annotated) and in Section 14 *[IC 27-1-3-7]* of the Acts of 1935, Chapter 162 (Section 39-3311 *[IC 27-1-3-7]*, Burns Indiana Statutes Annotated). This regulation *[760 IAC 1-12]* concerns the definition of "Equity Securities" and the requirements for filing information regarding the holding and transfer of such securities by officers, directors and certain other stockholders as defined in the Act *[IC 27-2-10]* of 1965. *(Department of Insurance; Reg 12,I; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 100; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 167; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-12-2 Definitions

Authority: IC 27-1-3-7
Affected: IC 27-2-10-6

Sec. 2. General Application. Definition of Certain Terms. (a) "Insurer" means any domestic stock insurance company, with an equity security subject to the provisions of Acts 1965, Chapter 5 *[IC 27-2-10]* (Section 39-3727 to Section 39-3734 *[IC 27-2-10]*, Burns Indiana Statutes) and not exempt thereunder.

(b) "Act" means Acts 1965, Chapter 5 *[IC 27-2-10]* (Section 39-3727 to Section 39-3734 *[IC 27-2-10]* Burns Indiana Statutes).

(c) "Officer" means a president, vice president, treasurer, actuary, secretary, controller and any other person who performs for the insurer functions corresponding to those performed by the foregoing officers.

(d) "Equity security" means any stock or similar security; or any voting trust certificate or certificate of deposit for such a security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right.

(e) Securities "held of record".

(1) For the purpose of determining whether the equity securities of an insurer are held of record by one hundred or more persons, securities shall be deemed to be "held of record" by each person who is identified as the owner of such securities on records of security holders maintained by or on behalf of the insurer, subject to the following:

(a) In any case where the records of security holders have not been maintained in accordance with accepted practice, any additional person who would be identified as such an owner on such records if they had been maintained in accordance with accepted practice shall be included as a holder of record.

(b) Securities identified as held of record by a corporation, a partnership, a trust whether or not the trustees are named, or other organization shall be included as so held by one person.

(c) Securities identified as held of record by one or more persons as trustees, executors, guardians, custodians or in other fiduciary capacities with respect to a single trust, estate or account shall be included as held of record by one person.

(d) Securities held by two or more persons as co-owners shall be included as held by one person.

(e) Each outstanding unregistered or bearer certificate shall be included as held of record by a separate person, except to the extent that the insurer can establish that, if such securities were registered, they would be held of record, under the provisions of this rule, by a lesser number of persons.

(f) Securities registered in substantially similar names where the insurer has reason to believe because of the address or other indications that such names represent the same person, may be included as held of record by one person.

(2) Notwithstanding subsection (1) of this paragraph:

(a) Securities held, to the knowledge of the insurer, subject to a voting trust, deposit agreement or similar arrangement shall be included as held of record by the record holders of the voting trust certificates, certificates of deposit, receipts or similar evidences of interest in such securities; provided however, that the insurer may rely in good faith on such information as is received in response to its request from a non-affiliated insurer of the certificates or evidences of

interest.

(b) If the insurer knows or has reason to know that the form of holding securities of record is used primarily to circumvent the provisions of the Act, the beneficial owners of such securities shall be deemed to be the record owners thereof.

(f) "Class" means all securities of an insurer which are of substantially similar character and the holders of which enjoy substantially similar rights and privileges. *(Department of Insurance; Reg 12,II,Sec 1; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 100; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 167; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, I, Sec 1 by 1971 amendment.*

760 IAC 1-12-3 Exempt transactions

Authority: IC 27-1-3-7
Affected: IC 27-2-10-2

Sec. 3. Transactions Exempted from the Operation of Section 2 *[IC 27-2-10-2]* of the Act. Any acquisition or disposition of any equity security by a director or officer of an insurer within six months prior to the date on which the Act shall first become applicable with respect to the equity securities of such insurer shall not be subject to the operation of Section 2 *[IC 27-2-10-2]* of the Act. *(Department of Insurance; Reg 12,II,Sec 2; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 102; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 168; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, I, Sec 2 by 1971 amendment.*

760 IAC 1-12-4 Beneficial ownership statements; forms

Authority: IC 27-1-3-7
Affected: IC 27-2-10-1

Sec. 4. Regulations under Section 1 of the Act. Filing of Statements. Initial statements of beneficial ownership of equity securities required by Section 1 *[IC 27-2-10-1]* of the Act shall be filed on Form A, attached hereto. Statements of changes in such beneficial ownership required by Section 1 *[IC 27-2-10-1]* shall be filed on Form B, attached hereto. All such statements shall be prepared and filed in accordance with the requirements of the applicable form.

STATE OF INDIANA
INSURANCE COMMISSIONER
FORM A
INITIAL STATEMENT OF BENEFICIAL OWNERSHIP OF SECURITIES
Filed pursuant to Acts 1965, Chapter 5, Section 1 (Sec. 39-3727 – Burns Indiana Statutes annotated)

_____
(Name of stock insurance company)

_____
(Name of person whose ownership is reported)

_____
(Business address of such person; street, city, state, zip code)

Relationship of such person to company named above. (See instruction 5) _____

_____

Date of event which requires the filing of this statement. (See instruction 6) _____

SECURITIES BENEFICIALLY OWNED

TITLE OF SECURITY (See instruction 7)	NATURE OF OWNERSHIP (See instruction 8)	AMOUNT OWNED beneficially (See instruction 9)

REMARKS: (See instruction 10)

Date of statement _____ _____

Signature

65-INS-A

STATE OF INDIANA
INSURANCE COMMISSIONER
FORM B
STATEMENT OF CHANGES IN BENEFICIAL OWNERSHIP OF SECURITIES
Filed pursuant to Acts 1965, Chapter 5, Section 1 (Sec. 39-3727 – Burns Indiana Statutes annotated)

(Name of stock insurance company)

(Name of person whose ownership is reported)

(Business address of such person; street, city, state, zip code)

Relationship of such person to company named above. (See instruction 5) _____

Statement for Calendar Month of _____, 19_____

CHANGES DURING MONTH AND MONTH-END OWNERSHIP (See instruction 6)

TITLE OF SECURITY (See instruction 7)	DATE OF TRANSACTION (See instruction 8)	AMOUNT BOUGHT or otherwise acquired (See instruction 9)	AMOUNT SOLD or otherwise acquired (See instruction 9)	NATURE OF OWNERSHIP (See instruction 10)	AMOUNT OWNED beneficially at end of month (See instruction 9)

REMARKS: (See instruction 11 &12)

Date of statement _____ _____

Signature

65-INS-B

(Department of Insurance; Reg 12,III, Sec 1-1; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 102; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 169; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, II, Sec 1-1 by 1971 amendment.

760 IAC 1-12-5 Determination of percentage of class of equity securities owned

Authority: IC 27-1-3-7
Affected: IC 27-2-10-1

Sec. 5. Ownership of More than Ten Per Cent of an Equity Security. (a) In determining, for the purpose of Section 1 *[IC 27-2-10-1]* of the Act whether a person is the beneficial owner, directly or indirectly, of more than 10 per cent of any class of any equity security, such class shall be deemed to consist of the total amount of such class outstanding, exclusive of any securities of such class held by or for the account of the insurer or a subsidiary of the insurer; except that for the purpose of determining percentage ownership of voting trust certificates or certificates of deposit for equity securities, the class of voting trust certificates or certificates of deposit shall be deemed to consist of the amount of voting trust certificates or certificates of deposit issuable with respect to the total amount of outstanding equity securities of the class which may be deposited under the voting trust agreement or deposit agreement in question, whether or not all of such outstanding securities have been so deposited. For the purpose of this section a person acting in good faith may rely on the information contained in the latest Convention Form Statement filed with the Commissioner with respect to the amount of securities of a class outstanding or in the case of voting trust certificates or certificates of deposit the amount thereof issuable.

(b) In determining for the purpose of Section 1 *[IC 27-2-10-1]* of the Act whether a person is the beneficial owner, directly or indirectly, of more than ten percent of any class of equity securities, such person shall be deemed to be the beneficial owner of securities of such class which such person has the right to acquire through the exercise of presently exercisable options, warrants or rights or through the conversion of presently convertible securities. The securities subject to such options, warrants, rights or conversion privileges held by a person shall be deemed to be outstanding for the purpose of computing, in accordance with paragraph (a), the percentage of outstanding securities of the class owned by such person but shall not be deemed outstanding for the purpose of computing the percentage of the class owned by any other person. This paragraph shall not be construed to relieve any person of any duty to comply with Section 1 *[IC 27-2-10-1]* of the Act with respect to any equity securities consisting of options, warrants, rights or convertible securities which are otherwise subject as a class to that section of the Act *[IC 27-2-10]*. *(Department of Insurance; Reg 12,III,Sec 1-2; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 102; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 169; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, II, Sec 1-2 by 1971 amendment.*

760 IAC 1-12-6 Disclaimer of beneficial ownership

Authority: IC 27-1-3-7
Affected: IC 27-2-10-1

Sec. 6. Disclaimer of Beneficial Ownership. Any person filing a statement may expressly declare therein that the filing of such statement shall not be construed as an admission that such person is, for the purpose of the Act *[IC 27-2-10]*, the beneficial owner of any equity securities covered by the statement. *(Department of Insurance; Reg 12,III,Sec 1-3; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 102; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 170; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, II, Sec 1-3 by 1971 amendment.*

760 IAC 1-12-7 Exemption of securities held by fiduciary or for account of insurer; reports

Authority: IC 27-1-3-7
Affected: IC 27-2-10-1; IC 27-2-10-2

Sec. 7. Exemptions from Sections 1 and 2 *[IC 27-2-10-1 and IC 27-2-10-2]* of the Act. (a) During the period of 12 months following their appointment and qualification, securities held by the following persons shall be exempt from Sections 1 and 2 *[IC 27-2-10-1 and IC 27-2-10-2]* of the Act:

(1) Executors or administrators of the estate of a decedent;

(2) Guardians or committees for an incompetent; and

(3) Receivers, trustees in bankruptcy, assigners for the benefit of creditors, conservators, liquidating agents, and other similar persons duly authorized by law to administer the estate or assets of other persons.

(b) After the 12-month period following their appointment or qualification the foregoing persons shall be required to file reports with respect to the securities held by the estates which they administer under Section 1 *[IC 27-2-10-1]* of the Act and shall be liable for profits realized from trading in such securities pursuant to Section 2 *[IC 27-2-10-2]* of the Act only when the estate being administered is a beneficial owner of more than 10 per cent of any class of equity security of an insurer subject to the Act *[IC 27-2-10]*.

(c) Securities reacquired by or for the account of an insurer and held by it for its account shall be exempt from Sections 1 and 2 *[IC 27-2-10-1 and IC 27-2-10-2]* during the time they are held by the insurer. *(Department of Insurance; Reg 12,III,Sec 1-4; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 102; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 170; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, II, Sec 1-4 by 1971 amendment.*

760 IAC 1-12-8 Exemption of securities purchased or sold by odd-lot dealers

Authority: IC 27-1-3-7
Affected: IC 27-2-10-2

Sec. 8. Exemptions from the Act of Securities Purchased or Sold by Odd-Lot Dealers. Securities purchased or sold by an odd-lot dealer (1) in odd lots so far as reasonably necessary to carry on odd-lot transactions or (2) in round lots to offset odd-lot transactions previously or simultaneously executed or reasonably anticipated in the usual course of business, shall be exempt from the provisions of the Act *[IC 27-2-10]* with respect to participation by such odd-lot dealer in such transactions. *(Department of Insurance; Reg 12,III,Sec 1-5; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 103; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 170; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, II, Sec 1-5 by 1971 amendment.*

760 IAC 1-12-9 Change in beneficial ownership

Authority: IC 27-1-3-7
Affected: IC 27-2-10-1

Sec. 9. Certain Transactions Subject to Section 1 *[IC 27-2-10-1]* of the Act. The acquisition or disposition of any transferable option, put, call, spread or straddle shall be deemed such a change in the beneficial ownership of the security to which such privilege relates as to require the filing of a statement reflecting the acquisition or disposition of such privilege. Nothing in this section, however, shall exempt any person from filing the statements required upon the exercise of such option, put, call, spread or straddle. *(Department of Insurance; Reg 12,III,Sec 1-6; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 103; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 170; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, II, Sec 1-6 by 1971 amendment.*

760 IAC 1-12-10 Ownership of securities held in trust

Authority: IC 27-1-3-7
Affected: IC 27-2-10-1

Sec. 10. Ownership of Securities Held in Trust. (a) Beneficial ownership of a security for the purpose of Section 1 *[IC 27-2-10-1]* shall include:

(1) The ownership of securities as a trustee whether either the trustee or members of his immediate family have a vested interest in the income or corpus of the trust,

(2) the ownership of a vested beneficial interest in a trust, and

(3) the ownership of securities as a settlor of a trust in which the settlor has the power to revoke the trust without obtaining the consent of all the beneficiaries.

(b) Except as provided in paragraph (c) hereof, beneficial ownership of securities solely as a settlor or beneficiary of a trust shall be exempt from the provisions of Section 1 *[IC 27-2-10-1]* where less than twenty percent in market value of the securities having a readily ascertainable market value held by such trust, determined as of the end of the preceding fiscal year of the trust, consists of equity securities with respect to which reports would otherwise be required. Exemption is likewise accorded from Section 1 *[IC 27-2-10-1]* with respect to any obligation which would otherwise be imposed solely by reason of ownership as settlor or beneficiary of securities held in trust, where the ownership, acquisition, or disposition of such securities by the trust is made without prior approval by the settlor or beneficiary. No exemption pursuant to this subsection shall, however, be acquired or lost solely as a result of changes in the value of the trust assets during any fiscal year or during any time when there is no transaction by the trust in the securities otherwise subject to the reporting requirements of Section 1 *[IC 27-2-10-1]*.

(c) In the event that 10 per cent of any class of equity security of an insurer is held in a trust, that trust and the trustees thereof as such shall be deemed a person required to file the reports specified in Section 1 *[IC 27-2-10-1]* of the Act.

(d) Not more than one report need be filed to report any holdings or with respect to any transaction in securities held by a trust, regardless of the number of officers, directors or ten per cent stockholders who are either trustees, settlors, or beneficiaries of a trust, provided that the report filed shall disclose the names of all trustees, settlors and beneficiaries who are officers, directors or ten per cent stockholders. A person having an interest only as a beneficiary of a trust shall not be required to file any such report so long as he relies in good faith upon an understanding that the trustee of such trust will file whatever reports might otherwise be required of such beneficiary.

(e) As used in this section the “immediate family” of a trustee means:

(1) a son or daughter of the trustee, or a descendant of either,

(2) a stepson or stepdaughter of the trustee,

(3) the father or mother of the trustee, or an ancestor of either,

(4) a stepfather or stepmother of the trustee,

(5) a spouse of the trustee.

For the purpose of determining whether any of the foregoing relations exists, a legally adopted child of a person shall be considered a child of such person by blood.

(f) In determining, for the purposes of Section 1 *[IC 27-2-10-1]* of the Act, whether a person is the beneficial owner, directly or indirectly, of more than 10 per cent of any class of any equity security, the interest of such person in the remainder of a trust shall be excluded from the computation.

(g) No report shall be required by any person, whether or not otherwise subject to the requirement of filing reports under Section 1 *[IC 27-2-10-1]*, with respect to his indirect interest in portfolio securities held by:

(1) a pension or retirement plan holding securities of an insurer whose employees generally are the beneficiaries of the plan,

(2) a business trust with over 25 beneficiaries.

(h) Nothing in this section shall be deemed to impose any duties or liabilities with respect to reporting any transaction or holding prior to its effective date. *(Department of Insurance; Reg 12,III,Sec 1-7; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 103; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 171; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, II, Sec 1-7 by 1971 amendment.*

760 IAC 1-12-11 Exemption of small transactions

Authority: IC 27-1-3-7
Affected: IC 27-2-10-1

Sec. 11. Exemption for Small Transactions. (a) Any acquisition of securities shall be exempt from Section 1 *[IC 27-2-10-1]* where

(1) The person effecting the acquisition does not within six months thereafter effect any disposition, otherwise than by way of gift, of securities of the same class, and

(2) The person effecting such acquisition does not participate in acquisitions or in dispositions of securities of the same class having a total market value in excess of $3,000 for any six months' period during which the acquisition occurs.

(b) Any acquisition or disposition of securities by way of gift, where the total amount of such gifts does not exceed $3,000

in market value for any six months' period, shall be exempt from Section 1 *[IC 27-2-10-1]* and may be excluded from the computations prescribed in paragraph (a)(2).

(c) Any person exempted by paragraph (a) or (b) of this section shall include in the first report filed by him after a transaction within the exemption a statement showing his acquisitions and dispositions for each six months' period or portion thereof which has elapsed since his last filing. *(Department of Insurance; Reg 12,III,Sec 1-8; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 105; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 172; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, II, Sec 1-8 by 1971 amendment.*

760 IAC 1-12-12 Exemption from IC 27-2-10-2 of transactions exempt from reporting requirements

Authority: IC 27-1-3-7
Affected: IC 27-2-10-1; IC 27-2-10-2

Sec. 12. Exemption from Section 2 *[IC 27-2-10-2]* of the Act of Transactions Which Need Not Be Reported under Section 1 *[IC 27-2-10-1]*. Any transaction which has been or shall be exempted from the requirements of Section 1 *[IC 27-2-10-1]* of the Act shall, insofar as it is otherwise subject to the provisions of Section 2 *[IC 27-2-10-2]*, be likewise exempted from Section 2 *[IC 27-2-10-2]*. *(Department of Insurance; Reg 12,III,Sec 1-9; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 105; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 173; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, II, Sec 1-9 by 1971 amendment.*

760 IAC 1-12-13 Exemption from IC 27-2-10-2 of transactions connected with a distribution

Authority: IC 27-1-3-7
Affected: IC 27-2-10-2

Sec. 13. Exemption from Section 2 *[IC 27-2-10-2]* of Certain Transactions Effected in Connection with a Distribution. (a) Any transaction of purchase and sale, or sale and purchase, of a security which is effected in connection with the distribution of a substantial block of securities shall be exempt from the provisions of Section 2 *[IC 27-2-10-2]* of the Act, to the extent specified in this section as not comprehended within the purpose of said Section of the Act *[IC 27-2-10]*, upon the following conditions:

(1) The person effecting the transaction is engaged in the business of distributing securities and is participating in good faith, in the ordinary course of such business, in the distribution of such block of securities;

(2) The security involved in the transaction is (A) a part of such block of securities and is acquired by the person effecting the transaction, with a view to the distribution thereof, from the insurer or other person on whose behalf such securities are being distributed or from a person who is participating in good faith in the distribution of such block of securities or (B) a security purchased in good faith by or for the account of the person effecting the transaction for the purpose of stabilizing the market price of securities of the class being distributed or to cover an over-allotment or other short position created in connection with such distribution; and

(3) Other persons not within the purview of Section 2 *[IC 27-2-10-2]* of the Act are participating in the distribution of such block of securities on terms at least as favorable as those on which such person is participating and to an extent at least equal to the aggregate participation of all persons exempted from the provisions of Section 2 *[IC 27-2-10-2]* of the Act by this section. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing such functions shall not preclude an exemption which would otherwise be available under this section.

(b) The exemption of a transaction pursuant to this section with respect to the participation therein of one party thereto shall not render such transaction exempt with respect to participation of any other party therein unless such other party also meets the conditions of this section. *(Department of Insurance; Reg 12,IV,Sec 2-1; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 105; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 173; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, III, Sec 2-1 by 1971 amendment.*

760 IAC 1-12-14 Exemption from IC 27-2-10-2 of acquisitions under stock bonus or stock option plans

Authority: IC 27-1-3-7
Affected: IC 27-2-10

Sec. 14. Exemption from Section 2 *[IC 27-2-10-2]* of Acquisitions of Shares of Stock and Stock Options under Certain Stock Bonus, Stock Option or Similar Plans. Any acquisition of shares of stock (other than stock acquired upon the exercise of an option, warrant or right) pursuant to a stock bonus, profit sharing, retirement, incentive, thrift, savings or similar plan, or any acquisition of a qualified or a restricted stock option pursuant to a qualified or a restricted stock option plan, or a stock option pursuant to an employee stock purchase plan, by a director or officer of an insurer issuing such stock or stock option shall be exempt from the operation of Section 2 *[IC 27-2-10-2]* of the Act if the plan meets the following conditions:

(a) The plan has been approved, directly or indirectly, (1) by the affirmative votes of the holders of a majority of the securities of such insurer present, or represented, and entitled to vote at a meeting duly held in accordance with the applicable laws of the State of Indiana, or (2) by the written consent of the holders of a majority of the securities of such insurer entitled to vote: provided, however, that if such vote or written consent was not solicited substantially in accordance with the proxy rules and regulations prescribed by the National Association of Insurance Commissioners, if any, in effect at the time of such vote or written consent, the insurer shall furnish in writing to the holders of record of the securities entitled to vote for the plan substantially the same information concerning the plan which would be required by any such rules and regulations so prescribed and in effect at the time such information is furnished, if proxies to be voted with respect to the approval or disapproval of the plan were then being solicited, on or prior to the date of the first annual meeting of security holders held subsequent to the later of (i) the date the Act first applies to such insurer, or (ii) the acquisition of an equity security for which exemption is claimed. Such written information may be furnished by mail to the last known address of the security holders of record within 30 days prior to the date of mailing. Four copies of such written information shall be filed with, or mailed for filing to, the Commissioner not later than the date on which it is first sent or given to security holders of the insurer. For the purposes of this paragraph, the term "insurer" includes a predecessor corporation if the plan or obligations to participate thereunder were assumed by the insurer in connection with the succession.

(b) If the selection of any director or officer of the insurer to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan, or the determination of the number or maximum number of shares of stock which may be allocated to any such director or officer or which may be covered by qualified, restricted or employee stock purchase plan stock options granted to any such director or officer, is subject to the discretion of any person, then such discretion shall be exercised only as follows:

(1) With respect to the participation of directors–

(A) by the board of directors of the insurer, a majority of which board and a majority of the directors acting in the matter are disinterested persons;

(B) by, or only in accordance with the recommendations of, a committee of three or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons; or

(C) otherwise in accordance with the plan, if the plan (i) specifies the number or maximum number of shares of stock which directors may acquire or which may be subject to qualified, restricted or employee stock purchase plan stock options granted to directors and the terms upon which, and the times at which, or the periods within which, such stock may be acquired or such options may be acquired and exercised; or (ii) sets forth, by formula or otherwise, effective and determinable limitations with respect to the foregoing based upon earnings of the insurer, dividends paid, compensation received by participants, options prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors.

(2) With respect to the participation of officers who are not directors–

(A) by the board of directors of the insurer or a committee of three or more directors; or

(B) by, or only in accordance with the recommendations of, a committee of three or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons.

For the purpose of this paragraph, a director or committee member shall be deemed to be a disinterested person only if such person is not at the time such discretion is exercised eligible and has not at any time within one year prior thereto been eligible for selection as a person to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan or any other plan of the insurer or any of its affiliates entitling the participants therein to acquire stock or qualified, restricted or employee stock purchase plan stock options of the insurer or any of its affiliates.

(3) The provisions of this paragraph shall not apply with respect to any option granted, or other equity security acquired, prior to the date that Sections 1, 2 and 3 *[IC 27-2-10-1 – IC 27-2-10-3]* of the Act first become applicable with respect

to any class of equity securities of any insurer.

(c) As to each participant or as to all participants the plan effectively limits the aggregate dollar amount or the aggregate number of shares of stock which may be allocated, or which may be subject to qualified, restricted, or employee stock purchase plan stock options granted, pursuant to the plan. The limitations may be established on an annual basis, or for the duration of the plan, whether or not the plan has a fixed termination date; and may be determined either by fixed or maximum dollar amounts or fixed or maximum numbers of shares or by formulas based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors which will result in an effective and determinable limitation. Such limitations may be subject to any provisions for adjustment of the plan or of stock allocable or options outstanding thereunder to prevent dilution or enlargement of rights.

(d) Unless the context otherwise requires, all terms used in this section shall have the same meaning as in the Act *[IC 27-2-10]* and in Section 1 *[760 IAC 1-12-2]* of these regulations. In addition, the following definitions apply:

(1) The term "plan" includes any plan, whether or not set forth in any formal written document or documents and whether or not approved in its entirety at one time.

(2) The definition of the terms "qualified stock option" and "employee stock purchase plan" that are set forth in Sections 422 and 423 of the Internal Revenue Code of 1954, as amended, are to be applied to those terms where used in this section. The term "restricted stock option" as defined in Section 424(b) of the Internal Revenue Code of 1954, as amended, shall be applied to that term as used in this section, provided however, that for the purposes of this section an option which meets all of the conditions of that Section, other than the date of issuance shall be deemed to be a "restricted stock option."

(3) The term "exercise of an option, warrant or right" contained in the parenthetical clause of the first paragraph of this section shall not include (i) the making of any election to receive under any plan and award of compensation in the form of stock or credits therefore, provided, that such election is made prior to the making of the award; and provided further that such election is irrevocable until at least six months after termination of employment; (ii) the subsequent crediting of such stock; (iii) the making of any election as to a time for delivery of such stock after termination of employment, provided that such election is made at least six months prior to any such delivery; (iv) the fulfillment of any condition to the absolute right to receive such stock; or (v) the acceptance of certificates for shares of such stock.

(Department of Insurance; Reg 12,IV,Sec 2-2; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 106; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 173; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, III, Sec 2-2 by 1971 amendment.

760 IAC 1-12-15 Exemption from IC 27-2-10-2 of redemption transactions

Authority: IC 27-1-3-7
Affected: IC 27-2-10-2

Sec. 15. Exemption from Section 2 *[IC 27-2-10-2]* of Certain Transactions in Which Securities are Received by Redeeming Other Securities. Any acquisition of an equity security (other than a convertible security or right to purchase a security) by a director or officer of the insurer issuing such security shall be exempt from the operation of Section 2 *[IC 27-2-10-2]* of the Act upon condition that

(a) the equity security is acquired by way of redemption of another security of an insurer substantially all of whose assets other than cash (or Government bonds) consist of securities of the insurer issuing the equity security so acquired, and which

(1) represented substantially and in practical effect a stated or readily ascertainable amount of such equity security,

(2) had a value which was substantially determined by the value of such equity security, and

(3) conferred upon the holder the right to receive such equity security without the payment of any consideration other than the security redeemed;

(b) no security of the same class as the security redeemed was acquired by the director or officer within six months prior to such redemption or is acquired within six months after such redemption;

(c) the insurer issuing the equity security acquired has recognized the applicability of paragraph (a) of this section by appropriate corporate action.

(Department of Insurance; Reg 12,IV,Sec 2-3; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 108; filed Jan 6, 1970, 8:40

am: Rules and Regs. 1971, p. 176; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, III, Sec 2-3 by 1971 amendment.

760 IAC 1-12-16 Exemption from IC 27-2-10-2 of long term profits incident to sales within six months of the exercise of an option

Authority: IC 27-1-3-7
Affected: IC 27-2-10-2; IC 27-2-10-3

Sec. 16. Exemption of Long Term Profits Incident to Sales Within Six Months of the Exercise of an Option. (a) To the extent specified in paragraph (b) of this section, the Commissioner hereby exempts as not comprehended within the purposes of Section 2 *[IC 27-2-10-2]* of the Act any transaction or transactions involving the purchase and sale, or sale and purchase, of any equity security where such purchase is pursuant to the exercise of an option or similar right either (1) acquired more than six months before its exercise, or (2) acquired pursuant to the terms of an employment contract entered into more than six months before its exercise.

(b) In respect of transactions specified in paragraph (a) the profits inuring to the insurer shall not exceed the difference between the proceeds of sale and the lowest market price of any security of the same class within six months before or after the date of sale. Nothing in this section shall be deemed to enlarge the amount of profit which would inure to such insurer in the absence of this section.

(c) The Commissioner also hereby exempts, as not comprehended within the purposes of Section 2 *[IC 27-2-10-2]* of the Act, the disposition of a security, purchased in a transaction specified in paragraph (a) of this section, pursuant to a plan or agreement for merger or consolidation, or reclassification of the insurer's securities, or for the exchange of its securities for the securities of another person which has acquired its assets, or which is in control, as defined in Section 368 (c) of the Internal Revenue Code of 1954, of a person which has acquired its assets, where the terms of such plan or agreement are binding upon all stockholders of the insurer except to the extent that dissenting stockholders may be entitled, under statutory provisions or provisions contained in the certificate of incorporation, to receive the appraised or fair value of their holdings.

(d) The exemptions provided by this section shall not apply to any transaction made unlawful by Section 3 *[IC 27-2-10-3]* of the Act or by any rules and regulations thereunder.

(e) The burden of establishing market price of a security for the purpose of this section shall rest upon the person claiming the exemption. *(Department of Insurance; Reg 12,IV,Sec 2-4; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 109; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 177; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, III, Sec 2-4 by 1971 amendment.*

760 IAC 1-12-17 Exemption from IC 27-2-10-2 of acquisitions and dispositions pursuant to merger or consolidation

Authority: IC 27-1-3-7
Affected: IC 27-2-10-2

Sec. 17. Exemption from Section 2 *[IC 27-2-10-2]* of Certain Acquisitions and Dispositions of Securities Pursuant to Merger or Consolidations. (a) The following transactions shall be exempt from the provisions of Section 2 *[IC 27-2-10-2]* of the Act as not comprehended within the purpose of said Section:

(1) The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to said merger or consolidation, owned 85 per cent or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company;

(2) The disposition of a security, pursuant to a merger or consolidation of an insurer which, prior to said merger or consolidation, owned 85 per cent or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company;

(3) The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to said merger or consolidation, held over 85 per cent of the combined assets of all the companies undergoing merger or consolidation, computed according to their book values prior to the merger or consolidation as determined by reference to their most recent available financial statements for a 12-month period prior to the merger or consolidation.

(4) The disposition of a security, pursuant to a merger or consolidation, of an insurer which, prior to said merger or consolidation, held over 85 per cent of the combined assets of all the companies undergoing merger or consolidation,

computed according to their book values prior to merger or consolidation, as determined by reference to their most recent available financial statements for a 12-month period prior to the merger or consolidation.

(b) A merger within the meaning of this section shall include the sale or purchase of substantially all the assets of one insurer by another in exchange for stock which is then distributed to the security holders of the insurer which sold its assets.

(c) Notwithstanding the foregoing, if an officer, director or stockholder shall make any purchase (other than a purchase exempted by this Section) of a security in any company involved in the merger or consolidation and any sale (other than a sale exempted by this Section) of a security in any other company involved in the merger or consolidation within any period of less than 6 months during which the merger or consolidation took place, the exemption provided by this Section shall be unavailable to such officer, director, or stockholder to the extent of such purchase and sale. *(Department of Insurance; Reg 12,IV,Sec 2-5; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 110; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 177; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, III, Sec 2-5 by 1971 amendment.*

760 IAC 1-12-18 Exemption from IC 27-2-10-2 of deposits or withdrawals under a voting trust or deposit agreement

Authority: IC 27-1-3-7
Affected: IC 27-2-10-2

Sec. 18. Exemption from Section 2 *[IC 27-2-10-2]* of Transactions Involving the Deposit or Withdrawal of Equity Securities Under a Voting Trust or Deposit Agreement. Any acquisition or disposition of an equity security involved in the deposit of such security under, or the withdrawal of such security from, a voting trust or deposit agreement, and the acquisition or disposition in connection therewith of the certificate representing such security, shall be exempt from the operation of Section 2 *[IC 27-2-10-2]* of the Act if substantially all of the assets held under the voting trust or deposit agreement immediately after the deposit or immediately prior to the withdrawal, as the case may be, consisted of equity securities of the same class as the security deposited or withdrawn: provided, however, that this section shall not apply to the extent that there shall have been either (a) a purchase of an equity security of the class deposited and a sale of any certificate representing an equity security of such class, or (b) a sale of an equity security of the class deposited and purchase of any certificate representing an equity security of such class (otherwise than in a transaction involved in such deposit or withdrawal or in a transaction exempted by any other provision of the regulations under Section 2 *[IC 27-2-10-2]* of the Act) within a period of less than six months which includes the date of the deposit or withdrawal. *(Department of Insurance; Reg 12,IV,Sec 2-6; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 110; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 178; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, III, Sec 2-6 by 1971 amendment.*

760 IAC 1-12-19 Exemption from IC 27-2-10-2 of conversion transactions

Authority: IC 27-1-3-7
Affected: IC 27-2-10-2

Sec. 19. Exemption from Section 2 *[IC 27-2-10-2]* of Certain Transactions Involving the Conversion of Equity Securities. (a) Any acquisition or disposition of an equity security involved in the conversion of an equity security which, by its terms or pursuant to the terms of the insurer's charter or other governing instruments, is convertible immediately or after a stated period of time into another equity security of the same insurer, shall be exempt from the operation of Section 2 *[IC 27-2-10-2]* of the Act: provided, however, that this section shall not apply to the extent that there shall have been either (1) a purchase of any equity security of the class convertible (including any acquisition of or change in a conversion privilege) and a sale of any equity security of the class issuable upon conversion, or (2) a sale of any equity security of the class convertible and any purchase of any equity security issuable upon conversion (otherwise than in a transaction involved in such conversion or in a transaction exempted by any other provision of the regulations under Section 2 *[IC 27-2-10-2]* of the Act) within a period of less than six months which includes the date of conversion.

(b) For the purpose of this section, an equity security shall not be deemed to be acquired or disposed of upon conversion of an equity security if the terms of the equity security converted require the payment or entail the receipt, in connection with such conversion, of cash or other property (other than equity securities involved in the conversion) equal in value at the time of conversion to more than 15 percent of the value of the equity security issued upon conversion.

(c) For the purpose of this section, an equity security shall be deemed convertible if it is convertible at the option of the holder

or of some other person or by operation of the terms of the security or the governing instruments. *(Department of Insurance; Reg 12,IV,Sec 2-7; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 111; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 179; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531) NOTE: Renumbered Reg 12, III, Sec 2-7 by 1971 amendment.*

760 IAC 1-12-20 Exemption from IC 27-2-10-2 of certain transactions involving the sale of subscription rights

Authority: IC 27-1-3-7
Affected: IC 27-2-10-2

Sec. 20. Exemption from Section 2 *[IC 27-2-10-2]* of Certain Transactions Involving the Sale of Subscription Rights. (a) Any sale of a subscription right to acquire any subject security of the same insurer shall be exempt from the provision of Section 2 *[IC 27-2-10-2]* of the Act, to the extent prescribed in this Section, as not comprehended with the purpose of said Section of the Act, if:

(1) Such subscription right is acquired, directly or indirectly, from the insurer without the payment of consideration;

(2) Such subscription right by its terms expires within 45 days after the issuance thereof;

(3) Such subscription right by its terms is issued on a pro rata basis to all holders of the beneficiary security of the insurer; and

(4) A registration statement under the Securities Act of 1933 is in effect as to each subject security, or the applicable terms of any exemption from such registration have been met in respect to each subject security.

(b) When used within this section the following terms shall have the meaning indicated:

(1) The term "subscription right" means any warrant or certificate evidencing a right to subscribe to or otherwise acquire an equity security;

(2) The term "beneficiary security" means a security registered pursuant to Section 12 of the Securities Exchange Act, to the holders of which a subscription right is granted;

(3) The term "subject security" means a security which is the subject of a subscription right.

(c) Notwithstanding anything contained herein to the contrary, if a person purchases subscription rights for cash or other consideration, then a sale by such person of subscription rights otherwise exempted by this Section will not be so exempted to the extent of such purchases within the six-month period preceding or following such sale. *(Department of Insurance; Reg 12,III,Sec 2-8; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 179; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-12-21 Exemption from IC 27-2-10-3 of transactions by disinterested broker

Authority: IC 27-1-3-7
Affected: IC 27-2-10-3

Sec. 21. Regulations under Section 3 *[IC 27-2-10-3]* of the Act. Exemption of Certain Securities from Section 3 *[IC 27-2-10-3]* of the Act. Any security shall be exempt from the operation of Section 3 *[IC 27-2-10-3]* of the Act to the extent necessary to render lawful under such Section the execution by a broker of an order for an account in which he has no direct or indirect interest. *(Department of Insurance; Reg 12,IV, Sec 3-1; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 112; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 180; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-12-22 Exemption from IC 27-2-10-3 of transactions related to a distribution

Authority: IC 27-1-3-7
Affected: IC 27-2-10-3

Sec. 22. Exemption from Section 3 *[IC 27-2-10-3]* of the Act of Certain Transactions Effected in Connection with a Distribution. Any security shall be exempt from the operation of Section 3 *[IC 27-2-10-3]* of the Act to the extent necessary to render lawful under such Section any sale made by or on behalf of a dealer in connection with a distribution of a substantial block of securities, upon the following conditions:

(a) The sale is represented by an over-allotment in which the dealer is participating as a member of an underwriting group, or the dealer or a person acting on his behalf intends in good faith to offset such sale with a security to be acquired by or on behalf of the dealer as a participant in an underwriting, selling or soliciting-dealer group of which the dealer is a member at

the time of the sale, whether or not the security to be so acquired is subject to a prior offering to existing security holders or some other class of persons; and

(b) Other persons not within the purview of Section 3 *[IC 27-2-10-3]* of the Act are participating in the distribution of such block of securities on terms at least as favorable as those on which such dealer is participating and to an extent at least equal to the aggregate participation of all persons exempted from the provisions of Section 3 *[IC 27-2-10-3]* of the Act by this section. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing such functions shall not preclude an exemption which would otherwise be available under this section.

(Department of Insurance; Reg 12,IV,Sec 3-2; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 112; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 180; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-12-23 Exemption from IC 27-2-10-3 of sales of securities to be acquired

Authority: IC 27-1-3-7
Affected: IC 27-2-10-1; IC 27-2-10-3

Sec. 23. Exemption from Section 3 *[IC 27-2-10-3]* of the Act of Sales of Securities To Be Acquired. (a) Whenever any person is entitled, as an incident to his ownership of an issued security and without the payment of consideration, to receive another security "when issued" or "when distributed," the security to be acquired shall be exempt from the operation of Section 3 *[IC 27-2-10-3]*, provided that:

(1) the sale is made subject to the same conditions as those attaching to the right of acquisition, and

(2) such person exercises reasonable diligence to deliver such security to the purchaser promptly after his right of acquisition matures, and

(3) such person reports the sale on the appropriate form for reporting transactions by persons subject to Section 1 *[IC 27-2-10-1]* of the Act.

(b) This section shall not be construed as exempting transactions involving both a sale of a security "when issued" or "when distributed" and a sale of the security by virtue of which the seller expects to receive the "when issued" or "when-distributed" security, if the two transactions combined result in a sale of more units than the aggregate of those owned by the seller plus those to be received by him pursuant to his right of acquisition. *(Department of Insurance; Reg 12,IV,Sec 3-3; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 112; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 181; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-12-24 Arbitrage transactions by director or officer of insurer

Authority: IC 27-1-3-7
Affected: IC 27-2-10

Sec. 24. Regulation under Section 5 *[IC 27-2-10-5]* of the Act. Arbitrage Transactions under Section 5 *[IC 27-2-10-5]* of the Act. It shall be unlawful for any director or officer of an insurer to effect any foreign or domestic arbitrage transaction in any equity security of such insurer, unless he shall include such transaction in the statements required by Section 1 *[IC 27-2-10-1]* of the Act and shall account to such insurer for the profits arising from such transaction, as provided in Section 2 *[IC 27-2-10-2]* thereof. The provisions of Section 3 *[IC 27-2-10-3]* shall not apply to such arbitrage transactions. The provisions of the Act *[IC 27-2-10]* shall not apply to any bona fide foreign or domestic arbitrage transaction insofar as it is effected by any person other than such director or officer of the insurer. *(Department of Insurance; Reg 12,VI,Sec 5-1; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 113; filed Jan 6, 1970, 8:40 am: Rules and Regs. 1971, p. 181; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 13. Solicitation and Sale of Specialty and Other Life Insurance and Annuities

760 IAC 1-13-1 Authority to promulgate rule; purpose of rule

Authority: IC 27-1-3-7
Affected: IC 4-22-2; IC 27-4-1-4

Sec. 1. Authority and Purpose of Regulation. The following rules *[760 IAC 1-13]* are promulgated pursuant to the rule making

authority provided in Indiana Insurance Law of 1935, Acts 1935, Chapter 162, Section 14 *[IC 27-1-3-7]*, Page 588, Section 39-3311 *[IC 27-1-3-7]*, Burns Indiana Statutes Annotated, and to implement the provisions of the "Unfair Competition and Practice Act," being Acts of 1947, Chapter 112 *[IC 27-4-1]*, Page 328, as amended in the Acts of 1955, Chapter 10, Section 1 *[IC 27-4-1-4]*, Page 8, being Section 39-5304 *[IC 27-4-1-4]* of Burns Indiana Statutes Annotated. The procedure followed in adopting these rules is that prescribed in the uniform method of promulgating rules by agencies of the State of Indiana, being Acts of 1945, Chapter 120 *[IC 4-22-2]*, Page 250, and being Section 60-1501 through 60-1511 *[IC 4-22-2]* of Burns Indiana Statutes Annotated. The purpose of these rules is to identify, clarify and prohibit certain acts and practices which are considered to be unsound methods of transacting the life insurance business in Indiana or unfair and deceptive acts and practices in the transaction of the business of life insurance in Indiana as provided by law and to establish certain requirements in the solicitation and sale of life insurance in Indiana to the end that policyholders and the insurance buying public shall not be misinformed or misled concerning contracts of life insurance or annuities purchased by them. *(Department of Insurance; Reg 13; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 115; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-13-2 Misleading phrases prohibited in life insurance and annuity policies

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 2. No insurance company, insurance agent or insurance company representative shall deliver within this state, or issue for delivery within this state, any life insurance policy or contract of annuity in which are used such words as "investment plan," "expansion plan," "profit-sharing," "charter plan," "founders plan," "surplus-sharing," or similar language in such context or under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser or prospective purchaser of life insurance to believe that he will receive or that it is probable he will receive something other than an insurance policy, or contract, or some benefit not provided in the policy or contract or some benefit not available to other persons of the same class and equal expectation of life. *(Department of Insurance; Reg 13,Rule 1; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 116; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-13-3 Distinction between surrender values and other benefits; separate premium statements

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 3. No insurance company, insurance agent or insurance company representative shall deliver within this state, or issue for delivery within this state, a policy of life insurance containing benefits in the form of "coupons" or "guaranteed annual endowment" benefits unless the premium charged for the insurance coverage and the premium charged for the "coupons" or "guaranteed annual endowment" benefits are prominently specified in the policy separately from each other in dollar amounts. This Rule 2 *[this section]* shall not apply to any policy in which the amount of any pure endowment or periodic benefit or benefits payable during any policy year is greater than the total annual premium for such year.

In connection therewith, the policy must provide for a distinction between the surrender values available under the insurance coverage as distinct from the "coupon" or "guaranteed annual endowment" benefits. This is to be accomplished by the use of a separate "table of values" in the policy. *(Department of Insurance; Reg 13,Rule 2; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 116; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-13-4 Disclosure of policy as life insurance (Repealed)

Sec. 4. *(Repealed by Department of Insurance; filed Jul 18, 1996, 9:00 a.m.: 19 IR 3466)*

760 IAC 1-13-5 Prohibited statements and sales practices

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 5. No life insurance company and no agent, solicitor, broker, or representative of such company shall, within this state:

(1) Make any statement or reference relating to the growth of the life insurance industry or to the tax status of life insurance companies in connection with any solicitation of an application for life insurance in a context which would reasonably be understood to interest a prospect in the purchase of shares of stock in an insurance company rather than in the purchase of a life insurance policy;
(2) Make any statement which reasonably gives rise to the inference that the insured or prospective insured will enjoy a status common to a stockholder or will acquire a stock ownership interest in the insurance company by virtue of purchasing the life insurance policy;
(3) Make any reference to or statement concerning a company's "Investment Department," "Insured Investment Department," or similar terminology in such a manner as to imply that the policy was sold or issued or is serviced by the investment department of the life insurance company;
(4) Make any statement or reference which would reasonably tend to imply that by purchasing a policy, the purchaser or prospective purchaser will become a member of a limited group of persons who may receive, in the payment of dividends, special advantages, benefits, or favored treatment unless such is specifically provided in the insurance contract; this clause has no relation or applicability to policies under which insured persons of one class of risk may receive dividends at a higher rate than persons of another class of risk;
(5) State or imply that only a limited number of persons, or limited class of persons, will be eligible to buy a particular kind of policy, unless such limitation is related to recognized underwriting practices and can be verified by the underwriting practices of the company;
(6) State or imply that policyholders who act as "centers of influence" for an insurance company will share, because of so acting, in the company's surplus earnings in some manner not available to other policyholders who are otherwise in the same class;
(7) State or imply that the principal amounts payable under coupons which may be attached to a life insurance policy represent interest, earnings, return on investment, or anything other than policy benefits, the cost of which is included in the total premium shown in the policy;
(8) Describe or refer to premium payments in language which states the payment is a "deposit," unless:
(a) the payment establishes a debtor-creditor relationship between the life insurance company and the policyholders and a showing is made as to when and how the deposit may be withdrawn; or
(b) the term is used in conjunction with the word "premium" or similar language in such a manner as to clearly indicate the true character of the payment;
(9) Provide any illustration or projection of future dividends on any policy unless:
(a) the illustration or projection is based on the experience currently used by the company for dividends or upon a scale adopted by the company, and
(b) the illustration or projection clearly indicates that the dividends shown are not guaranteed;
(10) Use the words "dividends," "cash dividends," "surplus," or similar phrases in such a manner as to state or imply that the payment of dividends is guaranteed or certain to occur;
(11) State or imply that a purchaser of a policy will share in a stated percentage or portion of the earnings of the company, unless such is specifically provided in the Insurance Contract;
(12) Make any statement or imply that projected dividends under a participating policy will be or can be sufficient at any time to assure the receipt of benefits, such as a paid-up policy without the further payment of premiums, unless the statement is accompanied by an adequate explanation as to:
(a) what benefits or coverage would be provided or discontinued at such time;
(b) the conditions under which this would occur;
(13) Describe a life insurance policy or premium payments therefor in terms of "units of participation" unless accompanied by other language fairly indicating their reference to a life insurance policy or to premium payments, as the case may be;
(14) Include in sales kits and prepared sales presentations proposed answers to a prospect's questions as to whether life insurance is being sold which are designed to avoid a clear and unequivocal statement that life insurance is the subject matter of the solicitation;
(15) State that the insured is guaranteed certain benefits if the policy is allowed to lapse without making an adequate explanation of the nonforfeiture benefits;
(16) Display to a prospective policyholder any printed material which includes illustrations, using dollar amounts, in

connection with the proposed sale of a life insurance policy or endowment benefits unless the printed material clearly identifies the subject to which the dollar amounts pertain and the subject has an economic relationship to the guaranteed values and dividends of the policy;

(17) Make any statement that a company makes a profit as a result of policy lapses or surrenders;

(18) Make comparisons to the past experience of other life insurance companies as a means of projecting possible experience of the soliciting company when the comparisons are designed to enhance the characteristics of the policy being sold by confining the comparisons to companies having favorable experience with that type of policy without a fair disclosure of companies which have had unfavorable experience and omitting references to other companies which have had unfavorable experience with such type policies, when it is within the knowledge of the company or agent that other companies have had such unfavorable experience;

(19) Fail or omit to indicate in a writing left with the applicant at the time an application for any life insurance policy containing "coupon" or "guaranteed annual endowment" benefits is obtained that there will be separately stated premium charge for these benefits; provided, however, that this clause (19) shall not apply where the amount of any pure endowment or periodic benefit or benefits payable during any policy year is greater than the total annual premium for such year.

(Department of Insurance; Reg 13,Rule 4; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 116; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-13-6 Violations; penalties; enforcement

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7; IC 27-1-3-8; IC 27-1-15.5; IC 27-1-16; IC 27-4-1

Sec. 6. Any violation of any of the provisions of this Regulation shall be deemed to be a violation of the Insurance Laws of this State when occurring in the advertising, promotion, solicitation, negotiation of or effecting the sale of life insurance and shall subject any person, firm or corporation so violating any provision of said Regulation to all the penalties provided by law. This conduct shall include any device or presentation, whether involving language or illustrations disseminated by means of sales kits, policy jackets or covers or forms, letters, personal presentations, visual aids or other media. The listing of such specific acts is not intended to imply that other acts not described, but otherwise unlawful, will be condoned. The procedure for enforcement of this Regulation shall be that prescribed in the "Unfair Competition and Practice Act" being Acts 1947, Chapter 112 *[IC 27-4-1]*, Page 328, as amended. In addition thereto, any Life Insurance Agent or Life Insurance Broker violating any provision of this Regulation shall be deemed to be in violation of the Insurance Laws of this State and subject to the provisions and the proceedings for revocation or suspension of license as provided in Acts 1945, Chapter 162, Page 588, being Section 225 *[sic., Refers to Acts 1935, Chapter 162, section 222. Codified as IC 27-1-16-5. Repealed by P.L.280-1977, SECTION 3. See, IC 27-1-15.5 concerning the licensure of insurance agents.]* of the Indiana Insurance Law. (Sec. 39-4601 et seq. *[IC 27-1-16]* Indiana Statutes.) *(Department of Insurance; Reg 13,Rule 5; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 118; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-13-7 Effective date of rule

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 7. This Regulation *[760 IAC 1-13]* shall become effective on May 1st, 1966. The Insurance Commissioner in his discretion may permit the continued use for a reasonable time of policy forms or related materials now in use and heretofore filed with the Insurance Department, even though the same may not conform to the requirements of this Regulation. *(Department of Insurance; Reg 13,Rule 6; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 119; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-13-8 Severability of provisions of rule

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 8. If any provision of this Regulation or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of the Regulation which can be given effect without the invalid provision or application, and to this end the provisions of this Regulation are severable. *(Department of Insurance; Reg 13,Rule 7; filed Jun 7, 1966, 9:00 am: Rules and Regs. 1967, p. 119; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-13-9 Change in forms to comply with rule (Repealed)

Sec. 9. *(Repealed by Department of Insurance; filed Jul 18, 1996, 9:00 a.m.: 19 IR 3466)*

Rule 14. Credit Life, Accident and Health Insurance–Compensation to Creditors and Agents (Repealed)
(Repealed by Department of Insurance; filed Sep 9, 2002, 3:00 p.m.: 26 IR 26)

Rule 15. Insurance Holding Company Systems (Repealed)
(Repealed by Department of Insurance; filed Oct 18, 1994, 3:55 p.m.: 18 IR 529)

Rule 15.1. Insurance Holding Company Systems

760 IAC 1-15.1-1 Authority; purpose
Authority: IC 27-1-3-7
Affected: IC 27-1-23-7

Sec. 1. This rule is promulgated pursuant to the authority granted by IC 27-1-23 concerning the regulation of insurance holding company systems. The purposes of this rule are to set forth rules and procedural requirements which the commissioner deems necessary to carry out the provisions of IC 27-1-23. The information called for by this rule is hereby declared to be necessary and appropriate in the public interest and for the protection of policyholders. *(Department of Insurance; 760 IAC 1-15.1-1; filed Oct 18, 1994, 3:55 p.m.: 18 IR 517; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-15.1-2 Definitions
Authority: IC 27-1-3-7
Affected: IC 27-1-2; IC 27-1-23-1

Sec. 2. (a) The definitions as set forth in IC 27-1-23 shall apply for purposes of this rule, in addition to the definitions contained in this section.

(b) As used in this rule, the following terms shall have the following meanings:

(1) "Executive officer" means any individual charged with active management and control in an executive capacity (including a president, vice president, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers) of a person, whether incorporated or unincorporated.

(2) "Foreign insurer" includes an alien insurer except where clearly noted otherwise.

(3) "Ultimate controlling person" means a controlling person within an insurance holding company system who is not controlled by any other person.

(c) The meaning of nomenclature or terminology not defined in this section or in IC 27-1-23 is according to the insurance code, IC 27, or industry usage if not defined in the code. *(Department of Insurance; 760 IAC 1-15.1-2; filed Oct 18, 1994, 3:55 p.m.: 18 IR 517; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-15.1-3 Forms; general requirements
Authority: IC 27-1-3-7
Affected: IC 27-1-23

Sec. 3. (a) A person required to file or amend a statement regarding a proposed acquisition of control under IC 27-1-23-2 shall furnish the required information on Form A as provided in section 4 of this rule.

(b) An insurer required to file or amend a registration statement under IC 27-1-23-3 shall furnish the required information on Form B as provided in section 5 of this rule.

(c) An insurer required to file an annual registration statement under IC 27-1-23-3 is also required to furnish the information required on Form C as provided in section 6 of this rule and shall file a Form C with the commissioner. A copy of Form C shall be filed in each state in which an insurer is authorized to do business if the commissioner of that state has notified the insurer of its request in writing.

(d) An insurer required to give notice of a proposed transaction under IC 27-1-23-4 shall furnish the required information on Form D as provided in section 7 of this rule.

(e) Forms A through D are intended to be guides in the preparation of the statements required by IC 27-1-23-2 through IC 27-1-23-4. They are not intended to be blank forms which are to be filled in.

(f) The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers are so prepared as to indicate to the reader the coverage of the items without the necessity of referring to the text of the items or the instructions thereto.

(g) All instructions, whether appearing under the items of the forms or elsewhere, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

(h) Three (3) complete copies of each statement, including exhibits and all other papers and documents filed as part thereof, shall be filed with the commissioner by personal delivery or mail addressed to: Insurance Commissioner, Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204.

(i) Statements should be prepared on paper eight and one-half (8 1/2) inches by eleven (11) inches in size and preferably bound at the top left hand corner. Exhibits and financial statements, unless specifically prepared for the filing, may be submitted in their original size.

(j) All copies of any statement, financial statement, or exhibit shall be clear, easily readable, and suitable for photocopying. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies.

(k) Statements, attached exhibits, and all other documents filed with the commissioner of the department of insurance shall be in the English language, and monetary values shall be stated in United States currency. *(Department of Insurance; 760 IAC 1-15.1-3; filed Oct 18, 1994, 3:55 p.m.: 18 IR 517; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-15.1-4 Form A

Authority: IC 27-1-3-7
Affected: IC 27-1-23-2; IC 27-1-23-23

Sec. 4. Form A, concerning proposed acquisition of control, shall be as follows:

FORM A
STATEMENT REGARDING THE
PROPOSED ACQUISITION OF CONTROL OF

Name(s) of domestic insurer(s) and any corporation(s) controlling such insurer(s) to which this Statement relates (hereinafter called the "company")

BY

Name(s) of person(s) by whom or on whose behalf acquisition of control is to be effected (hereinafter called the "acquiring party")

Filed with the
INDIANA INSURANCE COMMISSIONER
and sent to the company

Dated: _____, 19___

Name, title, address, and telephone number of individual to whom notices and correspondence concerning this Statement should be addressed:

_____
_____
_____
_____

FORM A

Item 1. Company and Method of Acquisition

State the name and address of the company and a brief description of how control is to be acquired.

Item 2. Identity and Background of Acquiring Party

(a) State the name and address of the acquiring party.

(b) If the acquiring party is not an individual, state the nature of its business operations for the past five (5) years or for such lesser period as the acquiring party and any predecessors thereof shall have been in existence, including information for such period relating to the acquisition or disposition of control by the acquiring party of any other person and any subsequent material change in the financial condition, management, or operations of such other person. Describe the business intended to be done by the acquiring party and its subsidiaries and any plans or proposals of the acquiring party for the conduct of the business or employment of the assets and surplus of the company.

(c) Furnish a chart or listing clearly presenting the identities of and the interrelationships among the acquiring party and all affiliates of the acquiring party. No affiliate need be identified if its total assets are less than one percent (1%) of the total assets of the acquiring party. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the acquiring party or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing, indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings looking toward a reorganization or liquidation are pending with respect to any such person, indicate which person and set forth the title of the court, the nature of proceedings, and the date when commenced.

Item 3. Identity and Background of Individuals Associated with Acquiring Party

(a) State the following with respect to (i) the acquiring party if he is an individual or (ii) all persons who are or who have been selected to become directors or executive officers of the acquiring party, or who perform or will perform functions appropriate to such positions, and owners of ten percent (10%) or more of the voting securities of the acquiring party, if the acquiring party is not an individual:

(1) Name and business address.

(2) Present principal business activity, occupation, or employment, including position and office held and the name, principal business, and address of any corporation or other organization in which such employment is carried on.

(3) Material occupations, positions, offices, or employment during the last five (5) years, giving the starting and ending dates of each and name, principal business, and address of any corporation or other organization in which each such occupation, position, office, or employment was carried on; if any such occupation, position, office, or employment required licensing by or registration with any federal, state, or municipal government agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension, or disciplinary proceedings in connection therewith.

(4) Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last ten (10) years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.

(b) Provide a completed current National Association of Insurance Commissioners (NAIC) biographical form for all individuals identified in Item 3(a).

Item 4. Source, Nature, and Amount of Consideration

(a) Describe the source, nature, and amount of funds or other consideration to be used in effecting the acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding, or trading voting securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes, and security arrangements relating thereto.

(b) Explain the criteria used in determining the nature and amount of such consideration.

(c) If the source of the consideration is a loan made in the lender's ordinary course of business and if the acquiring party

wishes the identity of the lender to remain confidential, he must specifically request that the identity be kept confidential and eliminate the lender's name from the Statement sent to the company.

Item 5. Future Plans for the Company

Describe any plans or proposals which the acquiring party may have to cause the company to declare an extraordinary dividend, to liquidate the company, to sell its assets or merge or consolidate it with any person, or to make any other material change in its investment policy, business, corporate structure, or management.

Item 6. Voting Securities to be Acquired

State the number of shares of the company's voting securities which the acquiring party, its affiliates, and any person listed in Item 3 plan to acquire, the terms of the offer, request, invitation, agreement, or acquisition, and the method by which the terms of the proposal were arrived at.

Item 7. Ownership of Voting Securities

State the amount of each class of any voting security of the company which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the acquiring party, its affiliates, or any person listed in Item 3.

Item 8. Contracts, Arrangements, or Understandings with Respect to Voting Securities

Give a full description of any contracts, arrangements, or understandings with respect to any voting security of the company in which the acquiring party, its affiliates, or any persons listed in Item 3 is involved, including, but not limited to, transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss, or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Identify the persons with whom such contracts, arrangements, or understandings have been entered into.

Item 9. Recent Purchases of Voting Securities

Describe any purchase of any voting security of the company by the acquiring party, its affiliates, or any person listed in Item 3 during the twelve (12) calendar months preceding the filing of this Statement. Include the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any such securities so purchased are hypothecated.

Item 10. Recent Recommendations to Purchase

Describe any recommendations to purchase any voting security of the company made by the acquiring party, its affiliates, or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the acquiring party, its affiliates, or any person listed in Item 3 during the twelve (12) calendar months preceding the filing of this Statement.

Item 11. Agreements with Broker-Dealers

Describe the terms of any agreement, contract, or understanding made with any broker-dealer as to solicitation of voting securities of the company for tender and the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard thereto.

Item 12. Contracts, Arrangements, or Understandings with Company Personnel

Give a full description of any existing or proposed contracts, arrangements, or understandings between the acquiring party and any present or former director, officer, or employee of the company, other than contracts, arrangements, or understandings entered into in the ordinary course of business with any insurance agent, solicitor, or broker. Identify the persons with whom such contracts, arrangements, or understandings have been entered into.

Item 13. Financial Statements and Exhibits

(a) Financial statements and exhibits shall be attached to this Statement as an appendix, but list under this Item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the persons identified in Item 2(c) for the preceding five (5) fiscal years (or such lesser period as the acquiring party and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such persons's *[sic.]* last fiscal year to a date not earlier than ninety (90) days prior to the filing of this Statement. Such financial statements may be prepared on either an individual basis or, unless the commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

The annual financial statements of the acquiring party shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the acquiring party and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the acquiring party is an insurer which is actively engaged in

the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of such person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under law and regulations of such state.

(c) File as exhibits copies of all tender offers for, requests or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the company and (if distributed) of additional soliciting material relating thereto; any proposed employment, consultation, advisory or management contracts concerning the company; annual reports to the shareholders of the acquiring party for the last two (2) fiscal years; and any additional documents or papers required or permitted by Form A or regulations of which such form is a part.

Item 14. Use of Affiliate's Assets

Furnish an informative description of any transaction in which the acquiring party received, employed, or used any affiliate's assets.

Item 15. Transactions with Affiliates

Furnish an informative description of any transaction or presently proposed transaction between the acquiring party and any of its affiliates in which either the acquiring party or the affiliate has a direct or indirect material interest. No information need be given as to any such transaction or series of similar transactions where the amount involved in the transaction or series of transactions, including all periodic payments or installments in the case of any lease or agreement providing for periodic payments or installments, does not or would not exceed one hundred thousand dollars ($100,000).

Item 16. Market Share Studies

Furnish copies of all studies, analysis, and reports which were prepared by or for the acquiring party or any affiliate of the acquiring party for the purpose of evaluating or analyzing the proposed acquisition of control with respect to market shares, competition, competitors, markets, and potential for growth or expansion into product or geographic markets.

Item 17. Competitive Impact

If the acquiring party or any affiliate of the acquiring party is an insurer, furnish the following information:

(1) The amount of any premiums, deposits, or annuity considerations received by the insurer during each of the last five (5) fiscal years (calculated on an accrual basis) for each line of insurance business conducted in any section of this state, and copies of annual statements for each of the last five (5) fiscal years filed by any such insurer with the insurance regulatory authority of its domiciliary jurisdiction.

(2) A full and complete description of any direct or indirect reinsurance relationship between the acquiring party or any affiliate of the acquiring party and the domestic insurer or any affiliate of the domestic insurer, together with copies of any treaties or contracts relating to that relationship.

(3) Any additional information requested by the commissioner to determine that the effect of the acquisition of control would not be substantially to lessen competition in any line of insurance business in any section of this state or tend to create a monopoly therein.

Item 18. Material Changes in Statement as Filed

If any material change occurs in the facts set forth in this statement filed in accordance with the rule and the requirements of IC 27-1-23-2 with the commissioner and sent to the insurer and any controlling corporation, an amendment made under or affirmation setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the commissioner and sent to the insurer and any controlling corporation within two (2) business days after any acquiring party learns of this change.

Item 19. Signature and Certification

Signature and certification of the following form:

SIGNATURE

Pursuant to the requirements of IC 27-1-23-2 and Regulations promulgated by the Indiana Insurance Commissioner, (Name of Acquiring Party) has caused this Statement to by duly signed on its behalf in the City of _____ and State of _____, on the _____ day of _____, 19___.

(SEAL)

_____
(Name of Acquiring Party)

By _____
Name Title

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that he has duly executed the attached Statement dated _____, 19___, for and on behalf of (Name of Acquiring Party), and that he is authorized to execute and file such instrument. Deponent further says that he is familiar with such instrument and the contents thereof and that the facts therein set forth are true to the best of his knowledge, information, and belief.

(Signature)_____
(Type or print name)_____

(Department of Insurance; 760 IAC 1-15.1-4; filed Oct 18, 1994, 3:55 p.m.: 18 IR 518; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-15.1-5 Form B

Authority: IC 27-1-3-7
Affected: IC 27-1-23-3

Sec. 5. Form B, concerning an insurance holding company system registration statement, shall be as follows:

FORM B
INSURANCE HOLDING COMPANY SYSTEM
ANNUAL REGISTRATION STATEMENT
Filed with the
INDIANA INSURANCE COMMISSIONER
By

_____
Name of Registrant
On behalf of the following Insurance Companies

Name	Address

Date:_____, 19__

Name, title, address, and telephone number of individual to whom notices and correspondence concerning this Statement should be addressed:

_____
_____
_____
_____

FORM B

Item 1. Identity and Control of Registrant

Furnish the exact name of each insurer registering or being registered (hereinafter called the "registrant"); the home office address and principal executive offices of each; the date on which each registrant became part of the insurance holding company system; and the method(s) by which control of each registrant was acquired and is maintained.

Item 2. Organizational Chart

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. No affiliate need be shown if its total assets are less than one percent (1%) of the total assets of the ultimate controlling person. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing, indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile.

Item 3. The Ultimate Controlling Person

As to the ultimate controlling person in the insurance holding company system, furnish the following information:

(1) Name.

(2) Home office address.

(3) Principal executive office address.

(4) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.

(5) The principal business of the person.

(6) The name and address of any person who holds or owns ten percent (10%) or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned.

(7) If court proceedings looking toward a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings, and the date when commenced.

Item 4. Biographical Information

Furnish the following for the directors and executive officers of the ultimate controlling person:

(1) The individual's name and address.

(2) His principal occupation and all offices and positions held during the past five (5) years.

(3) Any conviction of crimes other than minor traffic violations during the past ten (10) years.

Item 5. Transactions, Relationships, and Agreements

(a) Briefly describe the following agreements in force, relationships subsisting, and transactions currently outstanding or which have occurred during the last calendar year between the registrant and its affiliates:

(1) Loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the registrant or of the registrant by its affiliates.

(2) Purchases, sales, or exchanges of assets.

(3) Transactions not in the ordinary course of business.

(4) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the registrant's business.

(5) All management and service contracts and all cost-sharing arrangements, other than cost allocation arrangements based upon generally accepted accounting principles.

(6) Reinsurance agreements covering all or substantially all of one (1) or more lines of insurance of the ceding company.

(7) Dividends and other distributions to shareholders.

(8) Consolidated tax allocation agreements.

(9) Any pledge of the registrant's stock and/or of the stock of any subsidiary or controlling affiliate for a loan made to any member of the insurance holding company system.

(b) No information need be disclosed if such information is not material. Sales, purchases, exchanges, loans, or extensions of credit or investments involving one percent (1%) or less of the registrant's admitted assets as of the December 31 next preceding shall not be deemed material.

(c) The description shall be in a manner as to permit the proper evaluation thereof by the commissioner and shall include at least the following:

(1) The nature and purpose of the transaction.

(2) The nature and amounts of any payments or transfers of assets between the parties.

(3) The identity of all parties to such transaction.

(4) The relationship of the affiliated parties to the registrant.

(5) Whether prior notice of the transaction has been given to the commissioner.

Item 6. Litigation or Administrative Proceedings

Furnish a brief description of any litigation or administrative proceedings of the following types, either pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject and give the names of the parties and the court or agency in which such litigation or proceedings is or was pending:

(1) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto.

(2) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate controlling person, including, but not necessarily limited to, bankruptcy, receivership, or other corporate reorganizations.

Item 7. Statement Regarding Plan or Series of Transactions

The registrant shall furnish a statement that transactions entered into since the filing of the prior year's annual statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

Item 8. Financial Statements and Exhibits

(a) Financial statements and exhibits should be attached to this Statement as an appendix, but list under this Item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the ultimate controlling person as of the end of the person's latest fiscal year. If, at the time of the initial or annual registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis, or, unless the commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

Unless the commissioner otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of such insurer filed with the insurance department of the insurer's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) Exhibits shall include copies of the latest annual report to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or paper required or permitted by Form B or regulations of which such form is a part.

Item 9. Form C Required

A Form C, Summary of Registration Statement, must be prepared and filed with this Form B.

Item 10. Signature and Certification

Signature and certification of the following form:

SIGNATURE

Pursuant to the requirements of IC 27-1-23-3 and Regulations promulgated by the Indiana Insurance Commissioner, (Name of Registrant) has caused this Statement to by duly signed on its behalf in the City of _____ and State of _____, on the _____ day of _____, 19___.

(SEAL)

_____
(Name of Registrant)

By _____
Name Title

Attest:

_____
(Signature of Officer)

_____

(Title)

CERTIFICATION

The undersigned deposes and says that he has duly executed the attached Statement dated _____, 19___, for and on behalf of (Name of Registrant), and that he is authorized to execute and file such instrument. Deponent further says that he is familiar with such instrument and the contents thereof and that the facts therein set forth are true to the best of his knowledge, information, and belief.

(Signature)_____

(Type or print name)_____

(Department of Insurance; 760 IAC 1-15.1-5; filed Oct 18, 1994, 3:55 p.m.: 18 IR 521; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-15.1-6 Form C

Authority: IC 27-1-3-7
Affected: IC 27-1-23-3

Sec. 6. Form C, concerning summary of registration statement, shall be as follows:

FORM C

SUMMARY OF REGISTRATION STATEMENT

Filed with the

INDIANA INSURANCE COMMISSIONER

By

_____

Name of Registrant

On behalf of the following Insurance Companies

Name	Address

Date:_____, 19__

Name, title, address, and telephone number of individual to whom notices and correspondence concerning this Statement should be addressed:

_____
_____
_____
_____

FORM C

Item 1. Changes in Prior Statement

(a) Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the commissioner and shall include specific references to Item numbers in the annual registration statement and to the terms contained therein.

(b) Changes occurring under Item 2 of Form B insofar as changes in the percentage of each class of voting securities held by each affiliate are concerned, need only be included where such changes are ones which result in ownership or holdings of ten percent (10%) or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

(c) Changes occurring under Item 4 of Form B need only be included where an individual is, for the first time, made a director

or executive officer of the ultimate controlling person; a director or executive officer terminates his or her responsibilities with the ultimate controlling person; or in the event an individual is name president of the ultimate controlling person.

(d) If a transaction disclosed on the prior year's annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

Item 2. Statement Regarding Plan or Series of Transactions

The registrant shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.

Item 3. Signature and Certification

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of IC 27-1-23-3 and Regulations promulgated by the Indiana Insurance Commissioner, (Name of Registrant) has caused this Statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19___.

_____
(Name of Registrant)

By _____
Name Title

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that he has duly executed the attached Statement dated _____, 19___, for and on behalf of (Name of Registrant), and that he is authorized to execute and file such instrument. Deponent further says that he is familiar with such instrument and the contents thereof and that the facts therein set forth are true to the best of his knowledge, information, and belief.

(Signature)_____
(Type or print name)_____

(Department of Insurance; 760 IAC 1-15.1-6; filed Oct 18, 1994, 3:55 p.m.: 18 IR 523; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-15.1-7 Form D

Authority: IC 27-1-3-7
Affected: IC 27-1-23-4

Sec. 7. Form D, concerning prior notice of a transaction, shall be as follows:

FORM D
PRIOR NOTICE OF A TRANSACTION
Filed with the
INDIANA INSURANCE COMMISSIONER
By

_____
Name of Registrant
On behalf of the following Insurance Companies

Name Address

Date:_____, 19__

Name, title, address, and telephone number of individual to whom notices and correspondence concerning this Statement should be addressed:

_____
_____
_____
_____

FORM D

Item 1. Identity of Parties to Transaction

Furnish the following information for each of the parties to the transaction:

(1) Name.

(2) Home office address.

(3) Principal executive office address.

(4) The organizational structure, i.e., corporation, partnership, individual, trust, etc.

(5) A description of the nature of the parties' business operations.

(6) Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties.

(7) Where the transaction is with a nonaffiliate, the name(s) of the affiliate which will receive, in whole or in substantial part, the proceeds of the transaction.

Item 2. Description of the Transaction

Furnish the following information for each transaction for which notice is being given:

(1) A statement as to whether notice is being given under IC 27-1-23-4(b)(1), IC 27-1-23-4(b)(2), IC 27-1-23-4(b)(3), IC 27-1-23-4(b)(4), or IC 27-1-23-4(b)(5).

(2) A statement of the nature of the transaction.

(3) The proposed effective date of the transaction.

Item 3. Sales, Purchases, Exchanges, Loans, Extensions of Credit, Guarantees, or Investments

(a) Furnish a brief description of the amount and source of funds, securities, property, or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment, whether any provision exists for the purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice, a description of the terms of any securities being received, if any, and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements, and the like. If the transaction involves other than cash, furnish a description of the consideration, its cost, and its fair market value, together with an explanation of the basis for the evaluation.

(b) If the transaction involves a loan, extension of credit, or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit, or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

(c) If the transaction involves an investment, guarantee, or other arrangement, state the time period during which the investment, guarantee, or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees, or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

(d) No notice need be given if the maximum amount which can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit, or guarantee is less than:

(1) in the case of non-life insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent

(25%) of surplus as regards policyholders; or

(2) in the case of life insurers, three percent (3%) of the insurer's admitted assets;

each as of the December 31 next preceding.

Item 4. Loans or Extensions of Credit to a Nonaffiliate

(a) If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of, or make investments in any affiliate. Describe the amount and source of funds, securities, property, or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

(b) No notice need be given if the loan or extension of credit is less than:

(1) in the case of non-life insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders; or

(2) with respect to life insurers, three percent (3%) of the insurer's admitted assets;

each as of the December 31 next preceding.

Item 5. Reinsurance

(a) If the transaction is a reinsurance agreement or modification thereto, as described by IC 27-1-23-4(b)(3), furnish a description of the known and/or estimated amount of liability to be ceded and/or assumed, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and nonaffiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one (1) or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction and a brief statement as to the effect of the transaction upon the insurer's surplus.

(b) No notice need be given for reinsurance agreements or modifications thereto if the cash or invested assets in connection with the reinsurance agreement or modification thereto is less than five percent (5%) of the insurer's surplus as regards policyholders, as of the December 31 next preceding.

Item 6. Management Agreements, Service Contracts, and Cost-Sharing Arrangements

(a) For management agreements and service contracts, furnish the following:

(1) A brief description of the managerial responsibilities or services to be performed.

(2) A brief description of the agreement or contract, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.

(b) For cost-sharing arrangements, furnish the following:

(1) A brief description of the purpose of the agreement.

(2) A description of the period of time during which the agreement is to be in effect.

(3) A brief description of each party's expenses or costs covered by the agreement.

(4) A brief description of the accounting basis to be used in calculating each party's costs under the agreement.

Item 7. Signature and Certification

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of IC 27-1-23-4 and Regulations promulgated by the Indiana Insurance Commissioner, (Name of Applicant) has caused this Statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19___.

(SEAL)

_____
(Name of Applicant)

By _____
Name Title

Attest:

_____

(Signature of Officer)

_____

(Title)

CERTIFICATION

The undersigned deposes and says that he has duly executed the attached Statement dated _____, 19___, for and on behalf of (Name of Applicant), and that he is authorized to execute and file such instrument. Deponent further says that he is familiar with such instrument and the contents thereof and that the facts therein set forth are true to the best of his knowledge, information, and belief.

(Signature)_____

(Type or print name)_____

(Department of Insurance; 760 IAC 1-15.1-7; filed Oct 18, 1994, 3:55 p.m.: 18 IR 524; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-15.1-8 Forms; omissions

Authority: IC 27-1-3-7
Affected: IC 27-1-23

Sec. 8. (a) Where two (2) or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the date of execution, or other details, a copy of only one (1) of such documents need by filed together with a schedule identifying the omitted documents and setting forth the material details in which such documents differ from the copy filed.

(b) Information required need be given only insofar as it is known or reasonably available to the person filing the statement. If any required information is unknown and not reasonably available to the person filing, either because the obtaining thereof would involve unreasonable effort or expense or because it rests peculiarly within the knowledge of another person not affiliated with the person filing, the information may be omitted, subject to the following conditions:

(1) The person filing shall give such information on the subject as it possesses or can acquire without unreasonable effort or expense, together with the sources thereof.

(2) The person filing shall include a statement either showing that unreasonable effort or expense would be involved or indicating the absence of any affiliation with the person within whose knowledge the information rests and stating the result of a request made to such person for the information.

(Department of Insurance; 760 IAC 1-15.1-8; filed Oct 18, 1994, 3:55 p.m.: 18 IR 526; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-15.1-9 Forms; extensions of time to file

Authority: IC 27-1-3-7
Affected: IC 27-1-23

Sec. 9. If it is impractical to furnish any required information, document, or report at the time it is required to be filed, there may be filed with the commissioner as a separate document an application:

(1) identifying the information, document, or report in question;

(2) stating why the filing thereof at the time required is impractical; and

(3) requesting an extension of time for filing the information, document, or report to a specified date.

The application shall be deemed granted unless the commissioner within thirty (30) days after receipt thereof shall deny the application. *(Department of Insurance; 760 IAC 1-15.1-9; filed Oct 18, 1994, 3:55 p.m.: 18 IR 527; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-15.1-10 Forms; amendments

Authority: IC 27-1-3-7
Affected: IC 27-1-23

Sec. 10. The applicant shall promptly advise the commissioner of any material changes in the information furnished on Form A, Form B, or Form D arising subsequent to the date upon which the information was furnished but prior to the commissioner's disposition of the application. Any amendment to a form filed under this rule shall include on the top of the cover page a phrase, "Amendment No. _____ to" and shall indicate the date of the amendment and not the date of the original filing. *(Department of Insurance; 760 IAC 1-15.1-10; filed Oct 18, 1994, 3:55 p.m.: 18 IR 527; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-15.1-11 Alternate and consolidated registrations

Authority: IC 27-1-3-7
Affected: IC 27-1-23-3

Sec. 11. (a) Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register under IC 27-1-23-3. A registration statement may include information regarding any insurer in the insurance holding company system even if such insurer is not authorized to do business in this state. In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report which it is required to file in its state of domicile, provided:

(1) the statement or report contains substantially similar information required to be furnished on Form B; and

(2) the filing insurer is the principal insurance company in the insurance holding company system.

The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact, and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer shall set forth a simple statement of facts which will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurance holding company system.

(b) Any authorized insurer may take advantage of IC 27-1-23-3(h) or IC 27-1-23-3(i) without obtaining the prior approval of the commissioner. The commissioner, however, reserves the right to require individual filings if the commissioner deems such filings necessary in the interest of clarity, ease of administration, or the public good.

(c) A foreign or alien insurer otherwise subject to IC 27-1-23-3 shall not be required to register if in the domiciliary state it is subject to disclosure requirements and standards adopted by statute or regulation which are substantially similar to those contained in IC 27-1-23-3, provided, the commissioner may require a copy of the registration statement or other information filed with the domiciliary state or the principal insurer.

(d) The state of entry of an alien insurer shall be deemed to be its domiciliary state for purposes of IC 27-1-23-3.

(e) Any insurer not otherwise exempt or excepted from IC 27-1-23-3 may apply for an exemption by submitting a statement to the commissioner of the department of insurance setting forth its reason for being exempt.

(f) An amendment to Form B shall be filed by a registered insurer within fifteen (15) days after the end of the month in which it learns of any material change or addition in the information required to be furnished on Form B. An annual financial statement, an annual report to shareholders, and any proxy material of the ultimate controlling person shall be deemed a material change or addition requiring the filing of an amendment to Form B. *(Department of Insurance; 760 IAC 1-15.1-11; filed Oct 18, 1994, 3:55 p.m.: 18 IR 527; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-15.1-12 Standards

Authority: IC 27-1-3-7
Affected: IC 27-1-23-4

Sec. 12. (a) Requests by domestic insurers for approval of extraordinary dividends or any other extraordinary distribution to securityholders shall include the following:

(1) The date established for payment of the dividend and the amount of the proposed dividend.

(2) A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof, its cost, and its fair market value together with an explanation of the basis for valuation.

(3) The amounts and dates of all dividends (including regular dividends) paid within the period of twelve (12) consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year.

(4) A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus

in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs, including an analysis of the factors contained in IC 27-1-23-4(f).

(5) If the insurer is a life insurer, the net gain from operations for the twelve (12) month period ending December 31 next preceding.

(6) If the insurer is not a life insurer, the net income less realized capital gains for the twelve (12) month period ending December 31 next preceding and the two (2) preceding twelve (12) month periods.

(7) If the insurer is not a life insurer, the dividends paid to securityholders in the preceding two (2) calendar years.

(8) A balance sheet and statement of income for the period intervening from the last annual statement filed with the commissioner and the end of the month preceding the month in which the request for dividend approval is submitted.

(b) The factors set forth in IC 27-1-23-4(f) are not intended to be an exhaustive list. In determining the adequacy and reasonableness of an insurer's surplus, no single factor shall be controlling. The commissioner, instead, will consider the net effect of all of these factors, plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the commissioner will consider the extent to which each of these factors varies from company to company and in determining the quality and liquidity of investments in subsidiaries, the commissioner will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant. *(Department of Insurance; 760 IAC 1-15.1-12; filed Oct 18, 1994, 3:55 p.m.: 18 IR 528; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-15.1-13 Disclaimers and termination of registration

Authority: IC 27-1-3-7
Affected: IC 27-1-23-3

Sec. 13. A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person (hereinafter referred to as the "subject") shall contain the following information:

(1) The number of authorized, issued, and outstanding voting securities of the subject.

(2) With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities which are held of record or known to be beneficially owned, and the number of shares concerning which there is a right to acquire, directly or indirectly.

(3) All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person.

(4) A statement explaining why the person should not be considered to control the subject.

(Department of Insurance; 760 IAC 1-15.1-13; filed Oct 18, 1994, 3:55 p.m.: 18 IR 528; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-15.1-14 Incorporation of answers by reference

Authority: IC 27-1-3-7
Affected: IC 27-1-23-2; IC 27-1-23-3

Sec. 14. (a) Items on Form A and Form B may be answered by reference to answers to other items on the same form.

(b) Items on Form A, Form B, Form C, and Form D may be answered by reference to documents attached to such forms as exhibits, including, but not limited to, financial statements, annual reports, proxy statements, or any other written information. Where excerpts of documents have been attached as exhibits, the commissioner may require at any time that the complete documents be filed.

(c) References to answers or attached exhibits shall clearly identify the information to be incorporated and specifically state that such information is to be incorporated by reference. *(Department of Insurance; 760 IAC 1-15.1-14; filed Oct 18, 1994, 3:55 p.m.: 18 IR 528; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-15.1-15 Additional information and exhibits

Authority: IC 27-1-3-7
Affected: IC 27-1-23-2; IC 27-1-23-3

Sec. 15. In addition to the information expressly required to be included in Form A, Form B, Form C, and Form D, there shall be added such further material information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the form. Such exhibits shall be so marked as to indicate clearly the subject matters to which they refer. *(Department of Insurance; 760 IAC 1-15.1-15; filed Oct 18, 1994, 3:55 p.m.: 18 IR 528; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-15.1-16 Severability

Authority: IC 27-1-3-7
Affected: IC 27-1-23-13

Sec. 16. If any provision of this rule, or the application thereof to any person or circumstance, is held invalid, such invalidity shall not affect other provisions or applications of this rule which can be given effect without the invalid provision or application, and to that end the provisions of this rule are severable. *(Department of Insurance; 760 IAC 1-15.1-16; filed Oct 18, 1994, 3:55 p.m.: 18 IR 529; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 16. Unfair Competition–Replacement of Life Insurance Policies (Repealed)

(Repealed by Department of Insurance; filed Nov 26, 1979, 11:50 am: 3 IR 41)

Rule 16.1. Replacement of Existing Life Insurance Policies

760 IAC 1-16.1-1 Purpose of rule

Authority: IC 27-1-3-7
Affected: IC 27-4-1-8

Sec. 1. The purpose of 760 IAC 1-16.1 is:

(A) To regulate the activities of insurers and agents with respect to the replacement of all forms of existing life insurance, including annuities, except as specifically exempted by 760 IAC 1-16.1-4.

(B) To protect the interests of life insurance policyowners by establishing minimum standards of conduct to be observed in the replacement or proposed replacement of existing life insurance.

(C) To establish penalties for failure to comply with the requirements of 760 IAC 1-16.1.

(Department of Insurance; Reg 28, Sec 2; filed Oct 12, 1979, 4:50 pm: 2 IR 1568, eff Jan 1, 1980; filed Aug 20, 1982, 2:58 pm: 5 IR 2230, eff Jan 1, 1983; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-16.1-2 Replacement defined

Authority: IC 27-1-3-7
Affected: IC 27-4-1-8

Sec. 2. "Replacement" means any transaction in which new life insurance is to be purchased, and it is known or should be known to the proposing agent, or to the proposing insurer if there is no agent, that by reason of such transaction, existing life insurance has been or is to be:

(A) Lapsed, forfeited, surrendered, or otherwise terminated;

(B) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(C) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(D) Reissued with any reduction in cash value; or

(E) Pledged as collateral or subjected to borrowing or withdrawal, whether in a single loan or under a schedule of borrowing or withdrawal over a period of time for amounts in the aggregate exceeding twenty-five percent (25%) of the cash or loan value set forth in the policy.

(Department of Insurance; Reg 28, Sec 3; filed Oct 12, 1979, 4:50 pm: 2 IR 1569, eff Jan 1, 1980; filed Aug 20, 1982, 2:58 pm:

5 IR 2230, eff Jan 1, 1983; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-16.1-3 Definitions

Authority: IC 27-1-3-7
Affected: IC 27-4-1-8

Sec. 3. (A) "Conservation" means any attempt by the existing insurer or its agent to continue existing life insurance in force when the existing insurer has received a copy of the "Important Notice Regarding Replacement of Life Insurance" as required by 760 IAC 1-16.1-6(C)(3) from a replacing insurer. A conservation effort does not include such routine administrative procedures like late payment reminders, late payment offers or reinstatement offers.

(B) "Direct-Response Sales" means any sale of life insurance where the insurer does not utilize an agent in the sale or delivery of the policy.

(C) "Existing Insurer" means the insurance company whose policy is or will be changed or terminated in such a manner as described within the definition of "replacement".

(D) "Life Insurance" means all forms of life insurance, including annuities, except as exempted under 760 IAC 1-16.1-4.

(1) "Existing Life Insurance" means life insurance, as herein defined, that is in force, and includes life insurance under a binding or conditional receipt or a life insurance policy that is within an unconditional refund period.

(2) "Proposed Life Insurance" means life insurance, as herein defined, which is intended as a replacement for existing life insurance.

(E) "Type of Policy" means a short title which is descriptive of the premium and benefit patterns of a policy or a rider.

(F) "Replacing Insurer" means the insurance company that issues or proposes to issue a new policy which is a replacement of existing life insurance.

(G) "Sales Proposal" means individualized, written sales aids of all kinds, excluding the "Important Notice Regarding Replacement of Life Insurance", Policy Summaries, as required by 760 IAC 1-24, and Essential Policy Information Summaries which are used by an insurer, agent or broker in comparing existing life insurance to proposed life insurance in order to recommend the replacement or conservation of existing life insurance. Sales aids of a generally descriptive nature shall not be considered a Sales Proposal within the meaning of this definition.

(H) "Essential Policy Information Summary" means a form, statement or summary which must be provided to an insured by an existing insurer undertaking a conservation effort that includes at a minimum, but is not limited to, premiums, annual guaranteed cash values (shown for a period of twenty years or to age sixty-five, whichever is sooner), death benefits, dividends, if any, and the amount of policy indebtedness, unless otherwise exempted by or prohibited by law. This shall apply to the policy or policies and to all riders and endorsements attached thereto. *(Department of Insurance; Reg 28, Sec 4; filed Oct 12, 1979, 4:50 pm: 2 IR 1569, eff Jan 1, 1980; filed Aug 20, 1982, 2:58 pm: 5 IR 2230, eff Jan 1, 1983; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-16.1-4 Exemptions from rule

Authority: IC 27-1-3-7
Affected: IC 27-4-1-8

Sec. 4. Unless otherwise specifically included, 760 IAC 1-16.1 shall not apply to the replacement or proposed replacement of:

(A) Individual and group credit life insurance;

(B) Group life insurance, and life insurance policies issued in connection with a pension, profit-sharing or other benefit plan qualifying for tax deductibility of premiums, provided, however, that as to any plan described in this subsection, full and complete disclosure of all material facts shall be given to the administrator of any plan to be replaced;

(C) An existing life insurance policy in which a contractual change or conversion privilege is being exercised.

(Department of Insurance; Reg 28, Sec 5; filed Oct 12, 1979, 4:50 pm: 2 IR 1569, eff Jan 1, 1980; filed Aug 20, 1982, 2:58 pm: 5 IR 2231, eff Jan 1, 1983; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-16.1-5 Agent's duties

Authority: IC 27-1-3-7
Affected: IC 27-4-1-8

Sec. 5. (A) Each agent shall submit to the replacing insurer with or as part of each application for life insurance:
(1) A statement signed by the applicant as to whether or not such insurance will replace existing life insurance; and
(2) A signed statement as to whether or not the agent knows replacement is or may be involved in the transaction.
(B) Where a replacement is involved, the agent shall:
(1) Present to the applicant, not later than at the time of taking the application, a copy of the "Important Notice Regarding Replacement of Life Insurance" in the form as described in 760 IAC 1-16.1-12.5 or other substantially similar form approved by the Commissioner. The original copy of the Notice must be signed by and left with the applicant.
(2) Provide and leave with the applicant the original or a copy of all written Sales Proposals used for presentation to the applicant.
(3) Submit to the replacing insurer with the application, a copy of the "Important Notice Regarding Replacement of Life Insurance" signed by the agent and the applicant and a copy of all written Sales Proposals used for presentation to the applicant.
(C) Each agent who uses a Sales Proposal when conserving existing life insurance shall:
(1) Leave with the applicant the original or a copy of all Sales Proposals used in the conservation effort; and
(2) Submit to the existing insurer a copy of all Sales Proposals used in the conservation effort.

(Department of Insurance; Reg 28, Sec 6; filed Oct 12, 1979, 4:50 pm: 2 IR 1569, eff Jan 1, 1980; filed Aug 20, 1982, 2:58 pm: 5 IR 2232, eff Jan 1, 1983; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-16.1-6 Replacing insurer's duties

Authority: IC 27-1-3-7
Affected: IC 27-4-1-8

Sec. 6. Each replacing insurer shall:
(A) Inform its field representatives of the requirements of 760 IAC 1-16.1.
(B) Require with or as part of each completed application for life insurance:
(1) A statement signed by the applicant as to whether or not such insurance will replace existing life insurance; and
(2) A statement signed by the agent as to whether or not he or she knows replacement is or may be involved in the transaction.
(C) Where a replacement is involved:
(1) Require from the agent with the application for life insurance a copy of the "Important Notice Regarding Replacement of Life Insurance" signed by the agent and the applicant, and a copy of all written Sales Proposals used for presentation to the applicant.
(2) Furnish to the applicant a Policy Summary in accordance with the provisions of the Life Insurance Solicitation Regulation, 760 IAC 1-24.
(3) Send to the existing insurer a copy of the "Important Notice Regarding Replacement of Life Insurance" as required by 760 IAC 1-16.1-6(C)(1) within three working days of the date the application is received at its Home or Regional Office, or the date its policy is issued, whichever is sooner.
(4) Maintain copies of the "Important Notice Regarding Replacement of Life Insurance", the Policy Summary, and all Sales Proposals used, and a replacement register, cross indexed, by replacing agent and existing insurer to be replaced, for at least three years or until the conclusion of the next succeeding regular examination by the Insurance Department of its state of domicile, whichever is later.
(5) Provide, to the applicant, either in its policy or in a separate written notice which is delivered with the policy that the applicant has a right to an unconditional refund of all premiums paid, which right may be exercised within a period of twenty days commencing from the date of delivery of the policy.

(Department of Insurance; Reg 28, Sec 7; filed Oct 12, 1979, 4:50 pm: 2 IR 1570, eff Jan 1, 1980; filed Aug 20, 1982, 2:58 pm: 5 IR 2232, eff Jan 1, 1983; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-16.1-7 Direct response sales; insurer's duties

Authority: IC 27-1-3-7
Affected: IC 27-4-1-8

Sec. 7. Each insurer shall:

(A) Inform its responsible personnel of the requirements of 760 IAC 1-16.1.

(B) Require with or as part of each completed application for life insurance a statement signed by the applicant as to whether or not such insurance will replace existing life insurance.

(C) Where a replacement is involved in the solicitation of a direct-response sale:

(1) Request from the applicant with or as part of the application a list of all existing life insurance to be replaced. Such existing life insurance shall be identified by name of insurer.

(2) If the applicant furnishes the names of the existing insurers, then the replacing direct-response insurer shall mail the applicant an "Important Notice Regarding Replacement of Life Insurance" in a form substantially as described in 760 IAC 1-16.1-13.5 within three working days after receipt of the application and shall comply with all of the provisions of 760 IAC 1-16.1-6(C)(2), (3), (4), and (5), except that it need not maintain a replacement register required by 760 IAC 1-16.1-6(C)(4).

(3) If the applicant does not furnish the names of the existing insurers, then the replacing direct-response insurer shall at the time the policy is mailed to the applicant, include an "Important Notice Regarding Replacement of Life Insurance" in a form substantially as described in 760 IAC 1-16.1-13.5.

(Department of Insurance; Reg 28, Sec 8; filed Oct 12, 1979, 4:50 pm: 2 IR 1571, eff Jan 1, 1980; filed Aug 20, 1982, 2:58 pm: 5 IR 2233, eff Jan 1, 1983; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-16.1-8 Existing insurer's duties

Authority: IC 27-1-3-7
Affected: IC 27-4-1-8

Sec. 8. Each existing insurer shall inform its responsible personnel of the requirements of 760 IAC 1-16.1. Each existing insurer, or such insurer's agent, that undertakes a conservation effort shall:

(A) Within twenty days from the date the "Important Notice Regarding Replacement of Life Insurance" required by 760 IAC 1-16.1-6(C)(3) is received, furnish the policyowner with an Essential Policy Information Summary as described in 760 IAC 1-16.1-3(H) for the existing life insurance completed from the current policy year. Life Insurance cost index and equivalent level annual dividend figures need not be included in the Essential Policy Information Summary.

(B) Maintain a file containing the following:

(1) Copies of the "Important Notice Regarding Replacement of Life Insurance" required by 760 IAC 1-16.1-6(C)(3) received from replacing insurers; and

(2) Copies of Essential Policy Information Summaries prepared pursuant to subsection (A) of this section, and all Sales Proposals used to conserve the existing life insurance.

This material shall be indexed by the replacing insurer and held for three years or until the conclusion of the next regular examination conducted by the Insurance Department of its domicile, whichever is later. *(Department of Insurance; Reg 28, Sec 9; filed Oct 12, 1979, 4:50 pm: 2 IR 1571, eff Jan 1, 1980; filed Aug 20, 1982, 2:58 pm: 5 IR 2234, eff Jan 1, 1983; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-16.1-9 Violations; penalties; evidence of scienter

Authority: IC 27-1-3-7
Affected: IC 27-4-1-8

Sec. 9. (A) Any insurer, agent, representative, officer or employee of such insurer failing to comply with the requirements of 760 IAC 1-16.1 shall be subject to such penalties as may be appropriate under the Insurance Laws of Indiana, IC 27.

(B) 760 IAC 1-16.1 does not prohibit the use of additional material which is not in violation of 760 IAC 1-16.1 or any other Indiana Statute or Regulation.

(C) Policyowners have the right to replace existing life insurance after indicating in or as part of the applications for life insurance that such is not their intention; however, patterns of such action by policyowners who purchase the replacing policies from the same agent shall be deemed prima facie evidence of the agent's knowledge that replacement was intended in connection with the sale of those policies, and such patterns of action shall be deemed prima facie evidence of the agent's knowledge that replacement was intended in connection with the sale of those policies, and such patterns of action shall be deemed prima facie evidence of the agent's intent to violate 760 IAC 1-16.1. *(Department of Insurance; Reg 28, Sec 10; filed Oct 12, 1979, 4:50 pm: 2 IR 1572, eff Jan 1, 1980; filed Aug 20, 1982, 2:58 pm: 5 IR 2234, eff Jan 1, 1983; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-16.1-10 Severability of rule

Authority: IC 27-1-3-7
Affected: IC 27-4-1-8

Sec. 10. If any provision of 760 IAC 1-16.1 shall be held invalid, the remainder of 760 IAC 1-16.1 shall not be affected thereby. *(Department of Insurance; Reg 28, Sec 11; filed Oct 12, 1979, 4:50 pm: 2 IR 1572, eff Jan 1, 1980; filed Aug 20, 1982, 2:58 pm: 5 IR 2235, eff Jan 1, 1983; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-16.1-11 Effective date of rule

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 11. 760 IAC 1-16.1 as amended shall become effective January 1, 1983. *(Department of Insurance; Reg 28, Sec 12; filed Oct 12, 1979, 4:50 pm: 2 IR 1572, eff Jan 1, 1980; filed Aug 20, 1982, 2:58 pm: 5 IR 2235, eff Jan 1, 1983; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-16.1-12 Exhibit A; form of notice when existing and proposed policies are written by different companies (Repealed)

Sec. 12. *(Repealed by Department of Insurance; filed Aug 20, 1982, 2:58 pm: 5 IR 2237, eff Jan 1, 1983)*

760 IAC 1-16.1-12.5 Exhibit A; notice regarding replacement

Authority: IC 27-1-3-7
Affected: IC 27-4-1-8

Sec. 12.5.

EXHIBIT A

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

If you are thinking about DISCONTINUING or CHANGING an existing life insurance policy or annuity contract and BUYING a replacement, your decision could be a good one – or possibly a mistake. Make sure that you understand the facts. You should:

—Make a careful comparison of your existing policy and the proposed policy.
—Ask the company or agent that sold you your existing policy to provide you with complete information about it.
—Consider both sides before you decide.
—Determine what you want your insurance program to do.
—Consider your present health. You may have had a change which could affect your insurability, so make sure to continue your present policy until a new policy is delivered to you and accepted by you.

This form MUST be completed in triplicate and the original given to you by the agent proposing replacement no later than at the time you apply for the new policy. (This form must be completed and given to you even though the proposed replacement policy is with the same company that sold you your existing policy.)

EXISTING POLICY INFORMATION on _____

(Name of Insured)

COMPANY	TYPE OF POLICY	POLICY NO.	DATE OF ISSUE	FACE AMOUNT OF BASIC POLICY	TYPE OF OPTIONAL BENEFITS

(If more policies are involved, use additional sets of forms)

PROPOSED POLICY INFORMATION on _____
(Name of Insured)

COMPANY	TYPE OF* POLICY	FACE AMOUNT OF BASIC POLICY	TYPE OF OPTIONAL BENEFITS

Indiana Department of Insurance Regulation, 760 IAC 1-16.1 requires that the company making the replacement notify your existing insurance company that you may be replacing your existing policy. (You have the right, within twenty days after delivery of a replacement policy, to return it to the company and to claim an unconditional refund of all premiums paid on it.)

Applicant's/Insured's Signature

Date

Replacing Agent's Signature

Address

Telephone Number

Indiana License Number

* As shown on face of policy

(Department of Insurance; 760 IAC 1-16.1-12.5; filed Aug 20, 1982, 2:58 pm: 5 IR 2235, eff Jan 1, 1983; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-16.1-13 Exhibit B; form of notice when existing and proposed policies are written by same company (Repealed)

Sec. 13. *(Repealed by Department of Insurance; filed Aug 20, 1982, 2:58 pm: 5 IR 2237, eff Jan 1, 1983)*

760 IAC 1-16.1-13.5 Exhibit B; notice regarding replacement

Authority: IC 27-1-3-7
Affected: IC 27-4-1-8

Sec. 13.5.

EXHIBIT B

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

You are thinking about DISCONTINUING or CHANGING an existing life insurance policy or annuity contract and BUYING a replacement. Your decision could be a good one – or possibly a mistake. Make sure that you understand the facts. You should:

— Make a careful comparison of your existing policy and the proposed policy before you make a final decision.
— Ask the company or agent that sold you your existing policy to provide you with complete information about it.
— Determine what you want your insurance program to do.
— Consider your present health. You may have had a change which could affect your insurability, so make sure to continue your present policy until a new policy is delivered to you and accepted by you.

You have the right, within twenty days after delivery of a replacement policy, to return it to the company and to claim an unconditional refund of all premiums paid on it.
Indiana Department of Insurance Regulation, 760 IAC 1-16.1 requires that the company making the replacement notify your existing insurance that you may may be replacing your existing policy.

NAME OF APPLICANT	EXISTING COMPANY	TYPE OF PROPOSED POLICY

(Department of Insurance; 760 IAC 1-16.1-13.5; filed Aug 20, 1982, 2:58 pm: 5 IR 2236, eff Jan 1, 1983; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-16.1-14 Exhibit C; form of notice regarding replacement of life insurance (Repealed)

Sec. 14. *(Repealed by Department of Insurance; filed Aug 20, 1982, 2:58 pm: 5 IR 2237, eff Jan 1, 1983)*

760 IAC 1-16.1-15 Exhibit D; comparative information form (Repealed)

Sec. 15. *(Repealed by Department of Insurance; filed Aug 20, 1982, 2:58 pm: 5 IR 2237, eff Jan 1, 1983)*

Rule 17. Credit Bonding Insurance (Repealed)
(Repealed by Department of Insurance; filed Jul 17, 1986, 1:46 pm: 9 IR 3091)

Rule 18. Accident and Sickness Insurance–Advertising

760 IAC 1-18-1 Statement of principles
Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 1. Basic Principles of Interpretation. The proper promotion, sale and expansion of accident and sickness insurance are in the public interest, and the Rules *[760 IAC 1-18]* are to be construed in such a manner as not to restrict, inhibit or retard such promotion, sale and expansion.

In applying the Rules *[760 IAC 1-18]* it must be recognized that advertising plays an essential part in promoting a broader distribution of accident and sickness insurance. Advertising necessarily seeks to serve this purpose in various ways. Some advertisements are the direct or principal sales inducement and are designed to invite offers to contract. In other advertisements the function is to describe coverage broadly for the purpose of inviting inquiry for further information. Still other advertisements are solely for the purpose of promoting the reader's interest in the concept of accident and sickness insurance or of promoting the insurer sponsoring the advertisement. These differences should be given recognition through interpretation of the Rules *[760 IAC 1-18]*. Further, it should be recognized that exceptions, reductions and limitations have an important role in defining coverage for the purpose of keeping insurance costs within reasonable bounds.

Therefore, when applying the Rules *[760 IAC 1-18]* to a specific advertisement, it will be necessary to take into consideration the detail, character, purpose, use and entire content of the advertisement. *(Department of Insurance; Reg 19; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 401; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-2 Interpretation principles; group and individual insurance
Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 2. Specific Principles of Interpretation. The Rules *[760 IAC 1-18]* apply to group as well as individual accident and sickness insurance. Because the two differ widely in many respects, it follows that one interpretation will not always suffice for both. When that is the case, a specific interpretation for group is set forth. Some of the distinctions between individual and group that should be taken into account in applying the Rules *[760 IAC 1-18]* are:

(1) Frequently the prospective group policyholder is thoroughly conversant with insurance or employs competent insurance advisors.

(2) Group plans are often the result of collective bargaining whereunder the plan must continue in existence for a specified period of time even though the insurance carrier may be changed.

(3) Many group contracts are tailor-made to fit the policyholder's particular situation and are the result of extensive negotiations.

(4) Group insurance generally contemplates that all or part of the premium is to be paid by the group policyholder.

(5) The insurance provided by a group plan may be underwritten by several different insurers.

(6) Much group insurance material is prepared and published after the contract is written.

(7) Some states have statutory forms of group coverage.

NOTE: Notwithstanding the principles set out above, the interpretations which follow are intended for purposes of guidance only, and are not considered by the Indiana Department of Insurance as being all-inclusive. Where appropriate, a particular set of facts will be governed by recourse to the interpretations of the rules included herein; however, the rules may be interpreted other than as expressed herein in any case where the Department, in its discretion, feels that such treatment is warranted. *(Department of Insurance; Reg 19; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 401; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-3 Definitions

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 3. Section A. DEFINITIONS. (1) The term "advertisement" for the purpose of these regulations *[760 IAC 1-18]* shall include:

(a) printed and published material and descriptive literature of an insurer used in newspapers, magazines, radio, and television scripts, billboards and similar displays; and

(b) descriptive literature and sales aids of all kinds issued by an insurer for presentation to members of the public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and

(c) prepared sales talks, presentations and material for use by agents and brokers, and representations made by agents and brokers in accordance therewith.

(2) The term "policy" for the purpose of these regulations shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides accident or sickness benefits, or medical, surgical or hospital expense benefits, whether on a cash indemnity, reimbursement, or service basis, except when issued in connection with another kind of insurance other than life, and except disability and double indemnity benefits included in life insurance and annuity contracts.

(3) The term "insurer" for the purpose of these regulations shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, and any other legal entity engaged in the advertisement of a policy as herein defined.

(4) The term "exception" shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of risk not assumed under the policy.

(5) The term "reduction" shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction clause not been used.

(6) The term "limitation" shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

Interpretation of Section A 1 (a)

Advertisements for the sole purpose of obtaining employees, agents, agencies or brokers are among those not to be considered within the definition of an advertisement.

Interpretation of Section A 1 (b)

The definition of the word "Advertisement" is intended to include material used in the solicitation of renewals and reinstatements except for communications or notices which mention the cost of the insurance but do not describe benefits. It does not include: material in house organs of insurers; communications within an insurer's own organization not intended for

dissemination to the public; individual communications of a personal nature; nor correspondence between a prospective group policyholder and an insurer in the course of negotiating a group contract.

With respect to existing groups, reprints of group booklets after the effective date of the Rules *[760 IAC 1-18]* shall be considered within the definition of an advertisement however, until January 1, 1973, insurance companies shall not be prohibited from distributing already printed group booklets.

A general announcement from a group policyholder to eligible individuals that a contract has been written is not intended to be an advertisement within the meaning of the Rules *[760 IAC 1-18]* if it clearly indicates that it is preliminary to a booklet.

Interpretation of Section A 1 (c)

Materials to be used solely for the training and education of its employees, agents or brokers are not within the purview of the Rules *[760 IAC 1-18]*.

Interpretation of Section A 2

The language in Section A 2 "except disability and double indemnity benefits included in life insurance and annuity contracts" shall be interpreted to mean, "except disability and double indemnity benefits included in life insurance endowment or annuity contract or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (b) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract."

Interpretation of Section A 3

An insurer is not responsible for an advertisement which is not under its direct or indirect control. *(Department of Insurance; Reg 19,Sec A; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 402; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-4 Misleading or false statements

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 4. Section B. STANDARDS. ADVERTISEMENTS IN GENERAL. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases the meaning of which is clear only by implication or by familiarity with insurance terminology shall not be used. Interpretation of Section B 1

The purpose of the first sentence of Section B 1 is twofold. First, it states the general purpose of the Rules *[760 IAC 1-18]* by prohibiting advertisements which are not only false but which may mislead either in fact or by implication. It does for instance recognize that advertisements may be misleading even though literally true and capable of proof. Secondly, it establishes a broad principle designed to prohibit untruthful and misleading advertisements in addition to those principles covered by specific sections of the Rules *[760 IAC 1-18]*. To that extent it may be considered a "catch-all" rule.

The second sentence of this section is intended to prohibit the use of incomplete statements and words or phrases which, because of the reader's unfamiliarity with insurance terminology, have the tendency and capacity to mislead or deceive. It places no prohibition on the use of any particular words or phrases but does require that all terminology used in an advertisement, whether it be insurance terminology or otherwise, be sufficiently clear so as to avoid being misleading. In interpreting this particular portion of Section B 1, it must be recognized that insurance terminology is often essential to properly explain the coverage being advertised.

As a general principle, words or phrases which are commonly understood by the public with respect to insurance, for example, such words or phrases as premiums, policies, contracts, reinstatement, lapse, grace period, capital, assets, investments, legal reserve, insurer, insured, policyholders, insurance company and insurance usually need not be further clarified in the context of the advertisement. However, certain words or phrases may, unless adequately clarified in the context of the advertisement, mislead those who are not familiar with insurance terminology. *(Department of Insurance; Reg 19,Sec B1; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 404; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-5 Benefits payable, losses covered or premiums payable

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 5. ADVERTISEMENTS OF BENEFITS PAYABLE, LOSSES COVERED OR PREMIUMS PAYABLE. (a) Deceptive

Words, Phrases or Illustrations. Words, phrases or illustrations shall not be used in a manner which misleads or has the capacity and tendency to deceive as to the extent of any policy benefit payable, loss covered or premium payable. An advertisement relating to any policy benefit payable, loss covered or premium payable shall be sufficiently complete and clear as to avoid deception or the capacity and tendency to deceive.

Explanation:

(i) The words and phrases "all", "full", "complete", "comprehensive", "unlimited", "up to", "as high as", "this policy will pay your hospital and surgical bills" or "this policy will replace your income" or similar words or phrases shall not be used so as to exaggerate any benefit beyond the terms of the policy, but may be used only in such manner as fairly to describe such benefit.

(ii) A policy covering only one disease or a list of specified diseases shall not be advertised so as to imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

(iii) The benefits of a policy which pays varying amounts for the same loss occurring under different conditions, or which pays benefits only when a loss occurs under certain conditions, shall not be advertised without disclosing the limited conditions under which the benefits referred to are provided by the policy.

(iv) Phrases such as "this policy pays $1,800 for hospital room and board expenses" are incomplete without indicating the maximum daily benefit and the maximum time limit for hospital room and board expenses.

(b) Exceptions, Reductions and Limitations

When an advertisement refers to any dollar amount, period of time for which any benefit is payable, cost of policy, or specific policy benefit or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity and tendency to mislead or deceive.

Explanation:

(i) Waiting, Elimination, Probationary or Similar Periods

When a policy contains a time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such a loss, an advertisement shall disclose the existence of such periods.

(ii) Pre-existing Conditions

(a) An advertisement shall disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy.

(b) When a policy does not cover losses traceable to pre-existing conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder. This limits the use of the phrase "no medical examination required" and phrases of similar import.

Interpretation of Section B 2 *[this section]* generally

To interpret Section B 2 *[this section]* properly, it is necessary, first, to distinguish between Sections B 2(a) and B 2(b) *[subsections (a) and (b) of this section]*. Generally, the purpose of Section B 2(a) *[subsection (a) of this section]* is to prevent an insurer from exaggerating the extent of policy benefits or minimizing cost by using phraseology which either overstates benefits or is so incomplete as to leave an exaggerated idea of benefits in the mind of the reader. The first sentence of the Section and Explanations (i) and (ii) prohibit and explain exaggeration by overstatement. The second sentence of the Section and Explanations (iii) and (iv) prohibit and explain exaggeration by incompleteness.

Section B 2(b) *[subsection (b) of this section]* extends this principle of "no exaggeration." In essence it states that in certain types of advertisements the only way that exaggeration of benefits can be avoided is to set forth in the same advertisements certain of the limitations, exceptions and reductions affecting the benefits described.

Section B 2(a) *[subsection (a) of this section]* applies to any advertisement which discusses benefits. Section B 2(b) *[subsection (b) of this section]* applies only to an advertisement which discusses benefits to the extent of mentioning the dollar amount or time limit of the benefits or cost of the policy or benefits thereunder.

Because the basic purpose of both Rules *[subsections (a) and (b) of this section]* is the same–to prevent exaggeration, they must necessarily overlap at times. For example: In advertising a policy which contains an aggregate benefit limit, it would be improper to use alone the phrase, "no limit on the number of claims" because the second sentence of Section B 2(a) *[subsection (a)*

of this section] requires completion of the statement in some manner like "no limit on the number of claims until the aggregate amount X dollars has been paid." If elsewhere the advertisement contains a discussion of dollar amount or time limit of benefits or cost of the policy or its benefits, Section B 2(b) *[subsection (b) of this section]* requires that the aggregate amount be set forth because it is an important "limitation." Therefore, in this example, the aggregate amount should be set out because both Sections B 2(a) *[subsection (a) of this section]* and B 2(b) *[subsection (b) of this section]* require it.

The distinction between Sections B 2(a) *[subsection (a) of this section]* and B 2(b) *[subsection (b) of this section]* can best be explained as follows: Section B 2(a) *[subsection (a) of this section]* is only concerned with phraseology of benefit descriptions in an advertisement. Section B 2(b) *[subsection (b) of this section]* is not primarily concerned with phraseology, but, in advertisements to which it applies, in having certain limitations, exceptions and reductions set forth. It is simply coincidental that to meet the phraseology requirements of Section B 2(a) *[subsection (a) of this section]* it may sometimes be necessary to describe a limitation, exception or reduction.

Interpretation of Section B 2(a) *[subsection (a) of this section]* specifically

In interpreting Section B 2(a) *[subsection (a) of this section]* the following suggestions should be observed:

(1) Language which states or implies that a certain age group or groups are eligible for coverage when such is not the fact is unacceptable.

(2) Language which states or implies that each member under a "family" contract is covered as to the maximum benefits advertised when such is not the fact is unacceptable.

(3) Advertisements which indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of people are unacceptable if in the issuance of policies such distinctions are not maintained.

(4) The importance of diseases rarely or never found in the class of persons to whom the policy is offered shall not be exaggerated in an advertisement.

(5) Section B 2(a)(iii) *[subsection (a)(iii) of this section]* applies only to "limited benefit" type policies, the term to be given the connotation it usually receives in the industry.

(6) A limited benefit-type policy should be identified as such when advertised by disclosure of its limited character.

For example, automobile, air and railroad travel policy advertisements should disclose that they are limited to accidents resulting from automobile, air or railroad travel, as the case may be, as well as the limited manner in which the accident must occur, including any unusual conditions.

Advertising of policies which are specifically tailored to augment benefits available to medicare insureds should disclose in unmistakable language what medicare benefits the policy is designed to supplement, e.g., hospital benefits only and further which medicare benefits it will not supplement, e.g., does not pay doctors bills.

(7) Examples of what benefits may be paid under a policy shall not disclose only maximum benefits unless such maximum benefits are paid for losses from common and probable illnesses rather than exceptional or rare illnesses.

(8) When a range of hospital room rate benefits is set forth in an advertisement, it must be made clear that the insured will receive only the room rate benefit written or printed in the policy selected. Language which implies that the insured may select his room rate benefit at the time of hospitalization is unacceptable.

(9) Language which implies that the amount of benefits payable under a loss-of-time policy may be increased at time of disability according to the needs of the insured, is unacceptable.

(10) The term "confining sickness" is an abbreviated expression and in the case of either lifetime benefits or benefits for shorter periods the term must be explained in the advertisement. An example of an acceptable explanation would be: "Benefits are payable for total disability due to confining sickness only so long as the insured is necessarily confined indoors." Captions such as "Lifetime Sickness Benefits" or "Five Year Sickness Benefits" are incomplete if such benefits are subject to confinement requirements. When sickness benefits are subject to confinement requirements, captions such as "Lifetime Confining Sickness Benefits" or "Five Year Confining Sickness Benefits" would be acceptable.

(11) The following are specific examples of the type of advertising prohibited or permitted by Section B 2(a) *[subsection (a) of this section]*:

Advertisements shall not state that the insurer–

"pays hospital, surgical, etc. bills,"

"pays dollars to offset the cost of medical care,"

"safeguards your standard of living,"

"pays full coverage" or "pays complete coverage,"

"pays for financial needs,"

"provides for replacement of your lost paycheck,"

unless the statement in each instance is literally true. Where appropriate such or similar words or phrases may properly be used if preceded by the words "help," "aid," "assist" or similar words or phrases. Advertisements shall not emphasize the total amounts payable under hospital indemnity coverage or other benefits in such policy, such as benefits for private duty nursing, unless it provides with substantially equal prominence and in close conjunction with such statements the actual amounts payable per day for such indemnity or benefit.

(12) Advertisements which state that the premiums will not be changed in the future are not acceptable, unless such is the fact.

Any solicitation which states or implies immediate coverage or guaranteed issuance of a policy shall be made only if suitable administrative procedures exist so that the policy is issued within a reasonable time after the application is received.

Interpretation of Section B 2(b) *[subsection (b) of this section]* specifically

That part of Section B 2(b) *[subsection (b) of this section]* which reads as follows:

"When an advertisement refers to any dollar amount, period of time for which any benefit is payable, cost of policy, or specific policy benefit or the loss for which such benefit is payable, ***."

attempts to define the type of advertisement which must meet the requirements set forth in the remaining language of the Section.

The words "dollar amount" appearing above should be interpreted as meaning "dollar amount of benefits."

It is possible to have an advertisement which does not specifically mention dollar, time or cost, but accomplishes the same objective by indirection. For example, if there were a hospital and surgical expense policy which paid all incidental hospital expenses, it might be advertised as follows: "When you are covered under our hospital and surgical expense policy, we pay all your incidental hospital expenses." Or an advertisement of a major medical expense policy may truthfully promise to pay 75% of hospital, medical and surgical expenses in excess of the deductible. In both of these examples, language is employed which is sufficiently specific to indirectly disclose to the reader the dollar amount to which he may become entitled. The language of the rule mentioned above, to wit: "specific policy benefit or the loss for which such benefit is payable" was inserted to describe this type of advertisement.

As was noted in the "Basic Principles of Interpretation" advertisements generally fall within three categories. To properly apply the philosophy expressed in the first paragraph of the "Basic Principles", the meaning of Section B 2(b) *[subsection (b) of this section]* must be examined in the light of each category. The first category of advertisements includes those which are the direct or principal sales inducements and are designed to invite offers to contract, i.e., clearly attempt to persuade the reader or listener to purchase the policy or policies advertised. When such an advertisement mentions dollar amount or time limit of benefits or cost of policy or policy benefits, it is always subject to the limitations imposed by the mandatory portion of Section B 2(b) *[subsection (b) of this section]*.

The second category of advertisements includes those designed to attract the reader's interest in the policy or policies advertised so that he will inquire for further details and information. This type of advertisement usually describes benefits broadly. It may make some mention of dollar amount, time limits or cost. Such mention, however, does not in itself mean that the requirements of Section B 2(b) *[subsection (b) of this section]* are applicable if the advertisement clearly falls within the category of an invitation to inquire.

To illustrate the foregoing: A brief television commercial or a direct mail card may state, "X company invites you to inquire for full information about their $14 a day hospital expense policy." This advertisement is obviously not in the first category, an invitation to contract, but rather in the second category, an invitation to inquire. The viewer or reader could not reasonably decide to purchase the policy described on the basis of the information given even though it does mention a dollar amount.

But suppose the advertisement states, "X company invites you to inquire for full information about its $14 a day hospital expense policy which will cost you only 4¢ a day." Unlike the first example, it is more than a mere invitation to inquire for further details and should fall within the scope of Section B 2(b) *[subsection (b) of this section]*. The distinction between the two advertisements is plain, if it is borne in mind, in the examples given that at least two kinds of information are needed by a prospective purchaser to determine whether he wishes to buy. He needs to know (1) what he will get, and (2) what it will cost. If he only knows what he will get without knowing the cost or if he knows only what he must pay without knowing what he will get, his only reasonable course is to seek further information. The principle followed in the above examples is that if those advertisements which fall within the category of an invitation to inquire withhold some facts without which no one could reasonably decide to buy the policies advertised, such advertisements are not subject to the limitations imposed by Section B 2(b) *[subsection (b) of this section]*. It should be recognized that there is no single conclusive test and that each advertisement is weighed individually.

It is also true that if the description of dollar, time or cost is merely for the purpose of identifying the policy, Section B 2(b) *[subsection (b) of this section]* should not apply. Conversely, if the mention of dollar, time or cost is for the purpose of doing more than identifying the policy, Section B 2(b) *[subsection (b) of this section]*, may apply.

Thus, it can be seen that many advertisements falling within the "invitation to inquire" category are not subject to the requirements of Section B 2(b) *[subsection (b) of this section]*, but as has been shown, there will be times when their language is such as to make compliance necessary.

The third category of advertisements includes those of an institutional type. Rarely is it likely that dollar amounts, time limits, or cost will be mentioned in this class. Section B 2(b) *[subsection (b) of this section]*, therefore, has little or no application to advertisements in this category.

The phrase "no medical examination required" and phrases of similar import referred to in Rule B 2(b) (ii) (b) *[subsection (b) (ii) (b) of this section]* may be used, provided that (1) they are modified to indicate that they apply only to the issuance of the policy or to both issuance of the policy and payment of claims, whichever the case may be, (e.g. "No medical examination required to apply"; "No medical examination to apply for the policy or any benefits") and (2) additional wording is included in close conjunction with the phrases to indicate any time period following the effective date of the policy during which losses traceable to preexisting conditions are not covered. (E.g., "preexisting conditions not covered during first _____ years the policy is in force.")

We turn now to consideration of the mandatory portion of Section B 2(b) *[subsection (b) of this section]* which reads as follows:

> "*** it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity and tendency to mislead or deceive."

Where Section B 2(b) *[subsection (b) of this section]* applies, it is clear that it is not necessary to disclose all exceptions, reductions and limitations. The following are examples of exceptions, reductions and limitations that generally do affect the basic provisions and "without which the advertisement would have the capacity and tendency to mislead or deceive." Also included are examples of those that generally are not of sufficient significance to affect the basic provisions or to mislead if omitted. The lists are not intended to be complete and the advertiser should use the lists as a guide in determining the character of exceptions, reductions and limitations that do not appear.

GENERALLY **DO** AFFECT THE BASIC PROVISIONS AND WITHOUT WHICH THE ADVERTISEMENT WOULD HAVE THE CAPACITY AND TENDENCY TO MISLEAD OR DECEIVE

1. War or act of war.
2. While in armed services.
3. Territorial restriction on coverage within the U.S. and Canada.
4. Complete aviation exclusion.
5. Self-inflicted injury.
6. Injury inflicted by another person.
7. Pre-existing sickness or disease.
8. Exclusion or reduction for loss due to pre-existing bodily infirmities.
9. Exclusion or reduction for loss due to specific diseases, classes of diseases or types of injuries.
10. Confinement restrictions in disability policies such as house confinement, bed confinement and confinement to the premises.
11. Waiting periods.
12. Reduction in benefits because of age.
13. Any reduction in benefit during a period of disability.
14. Workmen's compensation or employers' liability law exclusion.
15. Occupational exclusion.
16. Violation of law.
17. Automatic benefit in lieu of another benefit.
18. Confinement in government hospital.
19. Maternity.
20. Miscarriage in accident and sickness policy.
21. Restrictions relating to organs not common to both sexes.
22. Restrictions on number of hospital hours before benefit accrues.

23. Insanity, mental diseases or disorders, or nervous disorder.
24. Dental treatment, surgery or procedures.
25. Cosmetic surgery.
26. **While** intoxicated or under the influence of narcotics, or other language not in conformity with the uniform policy provision law.
27. Unemployed persons.
28. Retired persons.
29. While handling explosives or chemical compounds.
30 While or as a result of participating in speed contests.
31. While or as a result of riding a motorcycle or motorcycle attachment.
32. While or as a result of participating in professional athletics.
33. While or as a result of participating in certain specified sports.
34. While or as a result of serving as a volunteer fireman or other hazardous occupations.
35. Riot or while participating in a riot.
36. Ptomaine poisoning.
37. Gas or poisonous vapor.
38. Sunstroke or heat prostration.
39. Freezing.
40. Poison ivy or fungus infection.
41. Requirement of permanent disability.

GENERALLY **DO NOT** AFFECT THE BASIC PROVISIONS AND WITHOUT WHICH THE ADVERTISEMENT WOULD NOT HAVE THE CAPACITY AND TENDENCY TO MISLEAD OR DECEIVE

1. Suicide, sane or insane.
2. Attempted suicide, sane or insane.
3. **Intentional** self-inflicted injury.
4. Territorial restriction with no limitation of coverage in the U.S. and Canada.
5. Aviation exclusion, except as passenger on commercial airlines.
6. Felony or illegal occupation.
7. Time limitation on death, dismemberment or commencement of disability following an accident.
8. All statutory standard and policy provisions, both mandatory and optional.
9. Requirement for regular care by a physician.
10. Definition of total disability.
11. Definition of partial disability.
12. Definition of hospital.
13. Definition of specific total loss.
14. Definition of injury.
15. Definition of physician or surgeon.
16. Definition of nurse.
17. Definition of recurrent disability.
18. Definition of commercial air travel.
19. Definition classifying hernia as a sickness.
20. Rest cures.
21. Diagnoses.
22. Prosthetics.
23. Cosmetic surgery, except as a result of accident occurring while policy is in force.
24. Dental treatment, surgery or procedures, except for injury to sound natural teeth occurring while policy is in force.
25. Bacterial infection, except pyogenic infection occurring through cut or wound caused by injury.
26. Eye examination for fitting of glasses or hearing aids.
27. Exclusion of sickness or disease in a policy providing only accident coverage.
28. Exclusion for miscarriage in policy providing only accident coverage.

Some advertisements of the first category relating to hospital indemnity coverage when used in newspaper and magazine advertising, which contain an application form or otherwise invite offers to contract, may disclose exceptions, reductions or limitations as required by Section B 2(b) *[subsection (b) of this section]* but the advertisement is so lengthy as to obscure the disclosure of the preexisting condition exclusion, the limitation on the payment of benefits for the first _____ days of hospital confinement if any, or the fact that the policy does not pay physician's benefits. In such circumstances special emphasis shall be given to such applicable exceptions, reductions or limitations in a prominent or clearly noticeable area in such advertisement. *(Department of Insurance; Reg 19,Sec B2; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 404; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-6 Disclosure of renewal, cancellation and termination provisions

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 6. NECESSITY FOR DISCLOSING POLICY PROVISIONS RELATING TO RENEWABILITY, CANCELLABILITY AND TERMINATION. An advertisement which refers to renewability, cancellability or termination of a policy, or which refers to a policy benefit, or which states or illustrates time or age in connection with eligibility of applicants or continuation of the policy, shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in manner which shall not minimize or render obscure the qualifying conditions.

Interpretation of Section B 3 *[this section]*

Section B 3 *[this section]* is divided into two parts. The first part defines the type of advertisement that is subject to the restrictions imposed upon such advertisement by the second part.

The first part of Section B 3 *[this section]* reads as follows:

"An advertisement which refers to renewability, cancellability or termination of policy, or which refers to a policy benefit, or which states or illustrates time or age in connection with eligibility of applicants or continuation of the policy ... "

Three distinct categories of advertisements are described:

In the first category is that type of advertisement "which refers to renewability, cancellability or termination of a policy." This language was inserted in the Section to prevent the advertisement of a non-cancellable or guaranteed renewable insurance policy in such a manner as to over-state the non-cancellable or guaranteed renewable feature. For example, suppose a non-cancellable and guaranteed renewable to age 65, at a level premium, loss-of-time policy was advertised briefly in the following manner: "X company sells a non-cancellable loss-of-time benefits policy." In this simple advertisement the insurer has chosen to discuss renewability or as the rule puts it "refers to renewability", etc. It is, therefore, bound by the provisions of Section B 3 *[this section]* and the language of its advertisement would have to read something like: "X company sells a non-cancellable and guaranteed renewable to age 65 loss-of-time benefits policy." Statements like "This policy safeguards your renewal" or "Yours for as long as you want it" are further examples of advertisements which refer to renewability so as to make them subject to the limitations imposed by Section B 3 *[this section]*. It is important to note that the restriction applies only to advertisements of specific policies.

In the second category is that type of advertisement "which refers to a policy benefit." In determining what is meant by the phrase "refers to a policy benefit," we must keep in mind the "Basic Principles of Interpretation." It will be recalled that these principles divide advertisements into three classes: "offers to contract," "invitations to inquire" and "institutional advertisements."

"Offers to contract" invariably describe benefits in considerable detail because their purpose is to convince the reader that he should purchase the policy described. This type of advertisement is always subject to the requirements of Section B 3 *[this section]*.

"Invitations to Inquire" are designed to attract the reader's interest in the policy so that he will inquire as to further details and information. Often these are brief advertisements used in television and radio commercials, pre-call letters, newspapers or magazines. The limitations imposed by Section B 3 *[this section]* should apply to this type of advertisement to the same extent that the limitations imposed by Section B 2(b) *[760 IAC 1-18-5(b)]* were found to apply to them. In other words, the language of the rule "refers to a policy benefit" should be interpreted to mean that an "invitation to inquire" which discusses dollar, time or cost extensively is subject to the limitations imposed by Section B 3 *[this section]*. If, however, the mention of dollar, time or cost is such that the advertisement withholds some facts without which no one could reasonably decide to buy the

policies advertised, the advertisement is not subject to the limitations imposed by Section B 3 *[this section]*. This is an application to Section B 3 *[this section]* of the principle established in the interpretation of Section B 2(b) *[760 IAC 1-18-5(b)]*.

The third class outlined in the Basic Principles of Interpretation is the institutional type advertisement. It is unlikely that this type of advertisement will ever be subject to Section B 3 *[this section]* unless it "refers to renewability," etc. of a specific policy. As was discussed in an earlier paragraph, it should be remembered that every advertisement, regardless of its class, is always subject to Section B 3 *[this section]* if it refers "to renewability, cancellability or termination of a policy."

In the third category is that type of advertisement "which states or illustrates time or age in connection with eligibility of applicants or continuation of the policy."

There are advertisements which do not "refer to renewability", etc. nor "refer to a policy benefit" but nevertheless are subject to Section B 3 *[this section]*.

These are advertisements which imply permanency by a discussion of age. For example, an advertisement of a cancellable policy may say: "Coverage–Ages 18 to 70", or "does not terminate at any specific age–no reduction in benefits as you grow older." Although technically truthful when standing alone, the above type of statement in an advertisement may imply permanency unless properly qualified. It is not the intent of the rules, however, to bring all statements about eligibility age under Section B 3 *[this section]* but only those statements which have the tendency and capacity to mislead as to the permanence and continuability of the protection. Simple statements disclosing the company's underwriting policy with respect to age such as "issued to people between the ages of 55 and 65" do not bring the advertisement under Section B 3 *[this section]*. It is essential for the advertiser to use words in describing the issue ages which cannot be construed to imply that the ages refer to renewability. One example has been given. Another approach would be to say something like, "For sale to persons between 18 and 59 years of age."

This completes a determination of the type of advertisement subject to Section B 3 *[this section]*. The remainder of Section B 3 *[this section]* relates to compliance and reads as follows:

"*** shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums, because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions."

The word "provisions" used above does not contemplate that the policy language must be used. Rather, the rule requires a summary of the pertinent information with respect to renewability, etc. This word was used merely to distinguish it from the word "conditions" used later in the paragraph.

In applying Section B 3 *[this section]*, the advertiser of a cancellable or optional-renewal policy is concerned only with the requirement that a summary of policy renewal provisions be set forth and is not concerned with that part of the rule which deals with "qualifying conditions." Advertisements of cancellable policies that come under Section B 3 *[this section]* must state that the contract in question is cancellable or renewable at the option of the company, as the case may be. For example, a policy which is cancellable should be advertised in a manner similar to, "This policy can be cancelled by the company at any time." Policies which are renewable at the company's option should be advertised in a manner similar to, "Renewable at the option of the Company," or "The company has the right to refuse renewal of this policy" or "The acceptance of a renewal premium is optional with the company."

With respect to the non-cancellable or guaranteed renewable type policy, the rule requires two things, first that a summary of the policy provisions with respect to renewability be set forth and, second, that anything that modifies the permanent character of the policy be set forth. The disclosure of provisions relating to renewability, etc., will require the use of language such as "non-cancellable", "guaranteed renewable", "non-cancellable and guaranteed renewable" or "renewable at the option of the insured."

In addition to the requirement for disclosure of "provisions relating to renewability", etc., the rule requires a statement of the qualifying conditions which constitute limitations on the permanent nature of the coverage. These customarily fall into three categories (1) age limits, (2) reservation of a right to change premiums and (3) the establishment of aggregate limits. For example, "non-cancellable and guaranteed renewable" does not fulfill the requirement of Section B 3 *[this section]*. If the policy contains a terminal insurance age of 65 a proper statement would be, "Non-cancellable and guaranteed renewable to age 65". An advertisement is not required to distinguish among terminations (a) on the insured's birthday, (b) on the policy anniversary nearest or following such date, (c) on the premium date following such date, or (d) any similar method of defining the termination date. If a right to change premiums is reserved, the statement must be amplified to language similar to,

"guaranteed renewable to age 65 but the company reserves the right to change premium rates on a class basis." If the contract contains an aggregate limit after which no further benefits are payable, the above statement must be amplified with the phrase, "Subject to maximum dollar amounts payable by the company as set out in the policy", or similar language. It should be borne in mind that one policy may have one or more of the three basic limitations. The advertisement must show those which the policy contains.

In addition to the above basic requirements, the rule necessitates a disclosure of "*** any modification of benefits, losses covered or premiums because of age or for other reasons ***". Because of the context of the section as a whole, this must be interpreted to mean only "modification of benefits", etc. which detract from the permanent nature of the coverage being offered. In other words, the rule is not a repetition of Section B 2(b) *[760 IAC 1-18-5(b)]* which requires the setting forth of certain limitations, exceptions and reductions when an advertisement describes benefits extensively. Rather, Section B 3 *[this section]*, under certain circumstances, requires only the description of those limitations which directly affect the permanent nature of the policy. For example, a provision for modification of benefits or increase of premium on account of change of occupation does not affect the permanent nature of the policy and, therefore, is not required to be disclosed by Section B 3 *[this section]*. Another example of a modification of benefits which does not affect the permanent nature of the coverage is a terminal reduction, i.e., a provision for the termination of benefit payments at or about the terminal age (65 for example). On the other hand, provisions for reduction of benefits at stated ages, other than terminal reductions, would have to be set forth because such a reduction does affect the permanent nature of the coverage. For example, a policy may contain a provision which reduces benefits 50% after age 50 although it is renewable to age 65. Such a reduction would have to be set forth. Also a provision for the elimination of certain hazards at any specific ages or after the policy has been in force for a specified time affects the permanent nature of the coverage and would have to be set forth. In this same category is the policy which provides for a stepped-up premium periodically. This, too, affects the permanency of coverage and would have to be set forth.

The foregoing is related to the type of advertisements subject to Section B 3 *[this section]* and what must be disclosed. The remainder of this interpretation relates to how the qualifying conditions must be disclosed. The language of the section reads: "*** in a manner which shall not minimize or render obscure the qualifying conditions."

The qualifying conditions should be set forth with the language describing renewability. For example, "Non-cancellable and guaranteed renewable to age 65." In this example, "to age 65" is properly stated with the words "non-cancellable and guaranteed renewable."

It should be mentioned that when Section B 3 *[this section]* requires that an advertisement state the terminal age of a permanent type policy, the statement of the age limit in the advertisement does not of itself bring the advertisement under Section B 2(b) *[760 IAC 1-18-5(b)]*.

In an advertisement of a group plan, subject to Section B 3 *[this section]*, it is not necessary to describe the terms of the policy concerning cancellability or non-renewability but the certificate holder must be advised therein that during the continuance of the contract his benefits are contingent upon his continued membership in the group.

(Department of Insurance; Reg 19,Sec B3; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 412; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-18-7 Method of disclosure

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 7. METHOD OF DISCLOSURE OF REQUIRED INFORMATION. All information required to be disclosed by these rules *[760 IAC 1-18]* shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading.

(a) Policy provided waiting periods, such as "there will be a waiting period of three (3) days before which sick benefits become payable," shall be printed as prominently as the amount of policy benefits payable.

(b) Policy provisions which reduce benefits due to age, such as "after age 65," shall be printed as prominently as the amount of policy benefits payable under the age specified.

(c) Statements such as "this policy pays $1,000 a month for hospitalization for accident only" must have the phrase

"ACCIDENT ONLY" printed in the same size print as the "$1,000."

Interpretation of Section B 4 *[this section]*

The purpose of this Section is to assure that all information required to be disclosed by the Rules *[760 IAC 1-18]* will be disclosed under one of two alternative methods in such a manner that the arrangement of the material itself will not have the capacity and tendency to confuse or mislead.

The first alternative permits the disclosure of exceptions, limitations, reductions and other restrictions either in the description of a specific benefit to which they relate or in a paragraph set out in close conjunction with the description of specific policy benefits. An example of incorporating a reduction in the description of a specific policy benefit follows:

$200.00 per month will be paid during total disability, beginning with the first day of such disability for as long as 24 months. Benefits are reduced 50 per cent for disability commencing after attainment of age 65.

An example of incorporating exceptions, limitations, reductions and other restrictions in a paragraph set out in close conjunction with the description of specific policy benefits follows:

THIS PLAN WILL PAY YOU

Accident Benefits

$1,000.00 for accidental death.

$200.00 per month for total disability, beginning with the first day of such disability for as long as 5 years.

$100.00 per month for partial disability, beginning with the first day of such disability or immediately following total disability for as long as 6 months.

Sickness Benefits

$200.00 per month for total disability, beginning with the 8th day of such disability for as long as 2 years.

Hospital and Surgical Benefits

$10.00 per day during hospital confinement from first day of such confinement for as long as 90 days.

$5.00 to $200.00 under comprehensive surgical schedule specifying the maximum payment for each operation listed. The maximum payment will vary depending upon the nature of your operation.

Total premium $_____ per _____.

The benefits described do not cover injury or disease: (1) existing before the policy date; (2) caused by war; or (3) occurring or commencing while in the Armed Forces.

The acceptance of a renewal premium is optional with the Company. Benefits payable are reduced 50% for disability commencing or loss occurring after attainment of age 65.

The second alternative would permit the disclosure of exceptions, limitations, reductions and other restrictions in some portion of the advertisement which is not in close conjunction with the provisions describing specific policy benefits, provided they were properly captioned.

For example, assuming that the last two paragraphs of the preceding example were separated from the description of the specific policy benefits by other material so as not to be in close conjunction with the benefit descriptions, then such paragraphs would have to be appropriately captioned as follows:

LIMITATIONS

The benefits described do not cover injury or disease: (1) existing before the policy date; (2) caused by war; or (3) occurring or commencing while in the Armed Forces. The acceptance of a renewal premium is optional with the Company. Benefits payable are reduced 50% for disability commencing or loss occurring after attainment of age 65.

The particular caption used above need not be used. For example, instead of the caption "Limitations," you might use "Exceptions," "Exclusions," "Not Covered," "Restrictions," "Extent of Coverage," or any other caption or combination of captions which would serve as notice of the exceptions, limitations or reductions from policy coverage.

An example of incorporating the amounts payable per day under a hospital indemnity policy which sets forth the total amount of indemnity payable would be: "This policy provides benefits in the amount of $600 per month at the rate of $20 per day when confined in a hospital."

Because of the different types of advertising media used to sell and promote accident and sickness insurance and the tremendous number and variety of techniques employed in each media, it was not practical to establish minimum and maximum requirements with respect to the size and style of type. Therefore, the "equal prominence" test was not employed in the Rule *[760 IAC 1-18]* nor should it be applied in the interpretation of the Rule *[760 IAC 1-18]*.

In summary, the purpose of this Rule *[760 IAC 1-18]* is to make certain that the information required to be disclosed is

presented clearly and in such a manner as to be readily noticed. *(Department of Insurance; Reg 19,Sec B4; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 416; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-8 Testimonials in advertising

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 8. TESTIMONIALS. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the advertisement including such statements is subject to all of the provisions of these rules *[760 IAC 1-18]*.

Interpretation of Section B 5 *[this section]*

The purpose of this Section is to establish certain requirements to be observed when using testimonials in advertisements. Considering the rule in its component parts: first, all testimonials must be genuine. They must not be fictitious. Under this rule, the manufacturing, unscrupulous editing or "doctoring up" of a testimonial is clearly prohibited as being false and misleading.

Next, the testimonial must represent the current opinion of the author. When a testimonial is submitted in good faith, setting forth appreciation for benefits and favorable treatment received from an insurer, it follows, as a natural corollary, that the use of such testimonial must be limited to those instances where the testimonial, no matter when written, is still representative of the current opinion of the author. In other words, at the time of publication, the author should still believe what he had originally stated. The purpose of this requirement is to eliminate, as misleading, the use of testimonials in those cases where it is reasonable to presume that the views expressed in the testimonial do not correctly reflect current opinion of the author. It is conceivable that the writer of a testimonial, for one reason or another, might change his mind and no longer entertain the views originally expressed. This does not mean, per se, that an insurer, in each instance, is required to check with the author each time his testimonial is used to ascertain that the views expressed have not altered; but an insurer may not use a testimonial when it has information indicating a substantial change of view on the part of the author. A testimonial should be checked before use in those instances when a change of views might be probable or reasonable to assume, particularly by virtue of the passage of a considerable period of time. In this connection an insurer should not use a testimonial for more than two years after the date it is originally given or following a prior confirmation without obtaining a confirmation from the author that the testimonial represents his then current opinion.

This Section, furthermore, prohibits testimonials which do not correctly reflect the present practices of the insurer. In other words, a testimonial even though recently written and otherwise usable under this Section, cannot be used if its statements describe practices no longer followed by the insurer. Such a testimonial would clearly be misleading.

A further possible misuse of testimonials is prohibited under the third part of the Section in which it is required that the testimonial must be applicable to the policy or benefit being advertised. This is intended to eliminate the using of a testimonial given in connection with one policy to advertise another policy where such use would be misleading. This, of course, does not apply to testimonials of a general nature in which the author expresses appreciation for courteous treatment received, the prompt payment of benefits, and so forth.

Finally, this Section states that the testimonial must be accurately reproduced. Any change or omission which distorts the plain meaning or intent of the testimonial as originally written is prohibited. However, a testimonial need not stand or fall in its entirety as originally written. Certainly if a testimonial should reveal information of a personal nature or contain a statement that is not absolutely correct insofar as company procedures or practices are concerned, an insurer may omit such matter from a testimonial and then use the residual matter in its advertising, provided, of course, that in so doing the original view is not distorted. Also, a portion or a segment of a testimonial can be used provided such use does not result in a meaning different from that when such excerpt appeared in context in the original testimonial. The basic purpose is to prohibit distortion of the original views expressed in the testimonials in such manner that their use would be misleading.

The purpose of the last sentence of the Section is to place responsibility for the truthfulness and accuracy of the testimonial on the insurer, and to prevent an insurer from avoiding the other requirements of the rules by the exclusive use of testimonial advertising. For example, if a testimonial refers to the dollar amount of any benefit, period of time for which any benefit is payable, or the cost of any benefit or policy, it would fall within the scope of Section B 2(b) *[760 IAC 1-18-5(b)]* and other applicable sections of the Rules *[760 IAC 1-18]* in the same manner as any other advertisements. However, a mere recital of the amount a company had paid to a claimant over a designated period of time in connection with a specific claim would not in itself render the

testimonial subject to Section B 2(b) *[760 IAC 1-18-5(b)]*.

When the amount of aggregate benefits which have been paid to a particular claimant are recited in a testimonial, the statement of this claim payment should not have the capacity and tendency to mislead a reader as to the true nature of the insurance coverage for which the payment was made. For example, if the author of a testimonial owned a loss-of-time policy which had paid him $600 loss-of-time benefits for a three-month disability, it might create the impression that the policy paid for hospital expenses if he said, "When I was in the hospital for three months, the company paid me $600.00." *(Department of Insurance; Reg 19, Sec B5; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 418; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-9 Statistics in advertising

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 9. USE OF STATISTICS. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact.

Interpretation of Section B 6 *[this section]*

If the term "loss ratio" is quoted, it should be based on (a) premiums received and benefits paid, or (b) premiums earned and losses incurred.

An advertisement representing the dollar amounts of claims paid must also indicate the period over which such claims have been paid. *(Department of Insurance; Reg 19,Sec B6; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 420; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-10 Offers of inspection of policy or premium refund

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 10. INSPECTION OF POLICY. An offer in an advertisement of free inspection of policy or offer of a premium refund is not a cure for misleading or deceptive statements contained in such advertisement. Furthermore, if such an offer is made, it must provide for a minimum of ten (10) days after delivery in which one may return the policy to the agent or company and receive a refund of any premiums paid.

Interpretation of Section B 7 *[this section]*

No comment believed necessary. *(Department of Insurance; Reg 19,Sec B7; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 420; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-11 Disclosure of plan or combination of policies referred to

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 11. IDENTIFICATION OF PLAN OR NUMBER OF POLICIES. (a) When a choice of the amount of benefits is referred to, an advertisement shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits.

(b) When an advertisement refers to various benefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.

Interpretation of Section B 8 *[this section]*

No comment believed necessary. *(Department of Insurance; Reg 19,Sec B8; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 420; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-12 References to other policies and competitors

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 12. DISPARAGING COMPARISONS AND STATEMENTS. An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or otherwise falsely disparage competitors, their policies, services or business methods.

Interpretation of Section B 9 *[this section]*

No comment believed necessary. *(Department of Insurance; Reg 19,Sec B9; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 421; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-13 Advertising beyond jurisdiction of licensing

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 13. JURISDICTIONAL LICENSING. An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

Interpretation of Section B 10 *[this section]*

An advertisement which contains testimonials from persons who reside in a state in which the insurer is not licensed or which refers to claims of persons residing in states in which the insurer is not licensed implies licensing in those states and therefore is in violation of this Section unless the advertisement otherwise states. *(Department of Insurance; Reg 19,Sec B10; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 421; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-14 Disclosure of identity of insurer

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 14. IDENTITY OF INSURER. The identity of the insurer shall be made clear in all of its advertisments. An advertisement shall not use a trade name, service mark, slogan, symbol or other device which has the capacity and tendency to mislead or deceive as to the true identity of the insurer.

Interpretation of Section B 11 *[this section]*

This section prohibits the use of the name of an agency or "_____ Underwriters" "_____ Plan" in type, size and location so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

This Section does not prohibit the use of the initials, the trade name or a portion of the corporate name of the insurer unless such use has the capacity and tendency to mislead or deceive as to the true identity of the insurer, in which event the insurer should set forth its full name and its home or principal office, i.e., city and state.

This Section prohibits an insurer from using an address so as to mislead or deceive as to its true identity or licensing status.

This Section prohibits an insurer from using envelopes or stationery which has imprinted thereon any name, service mark, slogan, symbol or other device which has the capacity or tendency to mislead or deceive as to imply that the insured or the policy advertised is connected with a governmental agency such as the Social Security Administration or the Veterans Administration. *(Department of Insurance; Reg 19,Sec B11; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 421; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-15 Group or quasi-group implications

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 15. GROUP OR QUASI-GROUP IMPLICATIONS. An advertisement of a particular policy shall not state or imply that prospective policyholders become group or quasi-group members and as such enjoy special rates or underwriting privileges, unless such is the fact.

Interpretation of Section B 12 *[this section]*

This Section prohibits the use of representations to any segment of individuals that a particular policy or coverage is available only to that, or similar segment of individuals as preferred risks, when actually such policy or coverage is available to eligible members of the public at large. There is no prohibition against advertising that a policy or coverage is available to only a particular

segment of individuals such as professional men, business men, etc., as preferred risks when in actual underwriting practice such is the fact.

This Section prohibits the solicitation of a particular class such as governmental employees by the use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when in fact the policy being advertised is sold only on an individual basis at regular rates. *(Department of Insurance; Reg 19,Sec B12; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 421; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-16 Introductory, initial or special offers

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 16. INTRODUCTORY, INITIAL OR SPECIAL OFFERS. (a) An advertisement shall not state or imply that a particular policy or combination of policies is an introductory, initial or special offer and that the applicant will receive advantages by accepting the offer, unless such is the fact. If an enrollment date by which one must accept an introductory, initial or special offer is provided, such offer shall not be repeated for six (6) months.

(b) No insurer may use a mail order solicitation form that requires the recipient to refuse the policy by signing said form and returning it to the insurer.

Interpretation of Section B 13 *[this section]*

This Section prohibits any statements or implication to the effect that only a specific number of policies will be sold or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless such is the fact.

This Section prohibits any statements or implication in the same advertising media to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, or that an individual will receive special advantages by enrolling within an open enrollment period or by a deadline date, unless such is the fact.

An applicant should be able to determine from the advertising the cost of his insurance. If the insurer charges an initial premium that differs from the renewal premium on the same mode, both the initial and renewal premium must be shown in the advertisement together with any increase in rate or reduction in coverage because of age. *(Department of Insurance; Reg 19,Sec B13; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 422; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-17 Third-party approval or endorsement

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 17. APPROVAL OR ENDORSEMENT BY THIRD PARTIES. (a) An advertisement shall not state or imply that an insurer or a policy has been approved or an insurer's financial condition has been examined and found to be satisfactory by a governmental agency, unless such is the fact.

(b) An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by an individual, group of individuals, society, association or other organization, unless such is the fact.

Interpretation of Section B 14(a) *[subsection (a) of this section]*

The word “approved” shall not be interpreted so as to permit an insurer to state or imply in an advertisement that a governmental agency has endorsed or recommended the insurer, its policies or its financial condition.

This Section does not prohibit an insurer from reproducing a portion of a filed report of examination of such insurer, conducted by one or more insurance departments, provided the portion reproduced is not taken out of context and thereby rendered untrue or misleading.

Interpretation of Section B 14(b) *[subsection (b) of this section]*

This Section requires current and valid endorsements. It would prohibit representations that a policy or plan of an insurer is a community health plan or program unless such policy or plan has been adopted by the particular community government for the residents of that community or has been so designated by law. *(Department of Insurance; Reg 19,Sec B14; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 422; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-18 Statements of services and settlement policies

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 18. SERVICE FACILITIES. An advertisement shall not contain untrue statements with respect to the time within which claims are paid or statements which imply that claim settlements will be liberal or generous beyond the terms of the policy. An advertisement promising cost savings derived from elimination of the agent shall also indicate that no direct personal service may be expected, if such is the fact.

Interpretation of Section B 15 *[this section]*

No comment believed necessary. *(Department of Insurance; Reg 19,Sec B15; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 423; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-19 Statements about insurer

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 19. STATEMENTS ABOUT AN INSURER. An advertisement shall not contain statements which are untrue in fact or by implication misleading with respect to the insurer's assets, corporate structure, financial standing, age or relative position in the insurance business.

Interpretation of Section B 16 *[this section]*

Among other things, this Section prohibits insurers which have been organized for only a brief period of time from advertising that they are "old" or from making similar untrue representations.

Illustrations of a "Home Office" building should not be used in a manner which will be misleading with respect to the actual size and magnitude of the insurer's business. *(Department of Insurance; Reg 19,Sec B16; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 423; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-18-20 Records; certificate of compliance

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4

Sec. 20. Section C. ENFORCEMENT PROCEDURES. (1) Advertising File: Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of individual policies and typical printed, published or prepared advertisements of blanket, franchise and group policies hereafter disseminated in this or any other state whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodical inspection by this Department. All such advertisements shall be maintained in said file for a period of not less than three years.

(2) Certificate of Compliance: Each insurer required to file an annual statement which is now or which hereafter becomes subject to the provisions of this rule must file with this Department together with its annual statement, a certificate executed by an authorized officer of the insurer wherein it is stated that to the best of his knowledge, information and belief the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws of this state as implemented and interpreted by this rule *[760 IAC 1-18]*. It is requested that the chief executive officer of each such insurer to which this rule *[760 IAC 1-18]* is addressed acknowledge its receipt and indicate its intention to comply therewith. *(Department of Insurance; Reg 19,Sec C; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 423; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 19. Group Accident and Sickness Insurance–Succeeding Carrier Requirements

760 IAC 1-19-1 Authority to promulgate rule; purpose of rule

Authority: IC 27-1-3-7
Affected: IC 27-8-5

Sec. 1. AUTHORITY AND PURPOSES. This regulation *[760 IAC 1-19]* is issued pursuant to the authority set out at I.C. 1971, 27-1-3-7.

Many Indiana citizens have purchased coverage under group disability policies which contain pre-existing conditions limitations. If the policy holder replaces an existing group disability policy issued by a succeeding carrier, pre-existing conditions limitations in the new policy may cause unfair hardship on the insureds. The purpose of this regulation *[760 IAC 1-19]* is to eliminate this hardship. *(Department of Insurance; Reg 20,I; filed Jun 25, 1975, 10:45 am: Rules and Regs. 1976, p. 172; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-19-2 Pre-existing condition limitations

Authority: IC 27-1-3-7
Affected: IC 27-8-5

Sec. 2. LIMITATIONS. In the case of persons insured under a prior carrier's group disability policy at the date of change in coverage to a succeeding carrier's group disability policy containing a pre-existing conditions limitation, during the period of time the limitation applies under the new policy, the level of benefits shall be the lesser of

(a) the benefits of the new plan determined without application of the pre-existing conditions limitation; or

(b) the benefits of the prior plan.

(Department of Insurance; Reg 20,II; filed Jun 25, 1975, 10:45 am: Rules and Regs. 1976, p. 172; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-19-3 Effective date of rule

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7; IC 27-8-5

Sec. 3. APPLICATION. All group disability policies issued on or after the effective date of this regulation *[760 IAC 1-19]* must contain policy provisions consistent with Sec. II *[760 IAC 1-19-2]* of this regulation. *(Department of Insurance; Reg 20,III; filed Jun 25, 1975, 10:45 am: Rules and Regs. 1976, p. 172; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 20. Individual Deferred Annuity Policies and Riders

760 IAC 1-20-1 Authority for rule

Authority: IC 27-1-3-7
Affected: IC 27-1-5-1

Sec. 1. AUTHORITY. This regulation *[760 IAC 1-20]* is issued pursuant to the authority set out at I.C. 1971, 27-1-3-7. *(Department of Insurance; Reg 21,I; filed Mar 3, 1976, 2:55 pm: Rules and Regs. 1977, p. 223; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-20-2 Applicability of rule

Authority: IC 27-1-3-7
Affected: IC 27-1-5-1

Sec. 2. (a) 760 IAC 1-20 shall apply to all individual deferred annuities except for variable deferred annuities, investment annuities, and annuities which fund structured settlements and shall not apply to group annuities.

A structured settlement is a means for funding a claim or suit or a prize, which has a corporate or governmental owner, by using an annuity contract with either deferred or immediate payments. *(Department of Insurance; Reg 21, II; filed Mar 3, 1976, 2:55 pm: Rules and Regs. 1977, p. 224; filed Apr 10, 1986, 11:00 am: 9 IR 2058; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-20-3 Required provisions

Authority: IC 27-1-3-7
Affected: IC 27-1-5-1

Sec. 3. (1) All individual deferred annuities shall provide guaranteed cash surrender values which are at least as favorable to the policyholder as accumulations of the following percentages of each payment or deposit at the contractually guaranteed interest rate:

(a) for fixed annual payment deferred annuities and flexible payment deferred annuities,

60% of those made in the first policy year,
85% of those made in policy years two through ten,
90% of those made after policy year ten

except that annuity policies having specified payments at early durations (e.g. the first or first and second policy years) which exceed specified payments for later durations shall have such excess subject to 90%;

(b) for single payment deferred annuities and annuity deposit funds, 90%:

(c) for any type of deferred annuity; percentages to be determined by the department.

(2) All deferred annuities must offer the option of a paid-up deferred annuity which is at least the actuarial equivalent of the cash surrender values offered.

(3) Reserves at any point in time during the deferred period shall be at least equal to the greater of:

(a) the cash surrender value actually available;

(b) the cash surrender value actually available accumulated at the contractually guaranteed interest rate to the earliest possible retirement age, and then discounted back at 4% to the point in time at which the reserve is being determined.

(4) No life insurance policy which has premiums at early durations (e.g. the first or first and second policy years) which exceed premiums for later durations, may include annuity deposit fund provisions except by a separate rider for which annual annuity payments or deposits are separately stated. These payments or deposits shall begin immediately upon issue of the policy and shall be level for each policy year.

(5) Deferred annuity cash surrender values shall not be subject to an automatic premium loan provision. If annuity benefits are provided by rider, this shall be so stated in the rider.

(6) There shall be a detailed description in the contract of the method of determining cash surrender values and paid-up non-forfeiture values. Except for flexible payment deferred annuities and annuity deposit funds, the contract shall contain a table showing the guaranteed cash surrender values and guaranteed paid-up deferred annuity amounts available under the contract on each policy anniversary for 20 policy years or until the latest possible retirement date permitted in the contract, if sooner.

(7) Advertisements shall be truthful and not misleading in fact or by implication. Advertisements showing cash surrender values at other than the contractually guaranteed interest rate shall show in equal prominence the same values at the contractually guaranteed interest rate.

(8) The contract shall have a provision for furnishing an annual report to the annuitant. This report shall show at least the following information for the immediately preceding year:

(a) cash surrender value at the beginning of the year;

(b) contributions (payments or deposits) during the year;

(c) distributions (withdrawals) during the year;

(d) earnings during the year;

(e) cash surrender value at the end of the year.

(9) Any deferred annuity policy or any life insurance policy containing annuity deposit provisions or having a rider attached at issue containing annuity deposit provisions must contain an unrestricted right to return the policy to the insurer or to the agent through whom it was purchased, within ten days from the date it is received by the policyholder, for a full return of all monies paid by the policyholder. This provision must be conspicuously shown on the face of the policy.

(10) No deferred annuity policy or rider which is not in compliance with 760 IAC 1-20 will be approved for issue in this state on or after the effective date of 760 IAC 1-20. As of September 1, 1976, approval is withdrawn from all deferred annuity policies and riders approved prior to the effective date, which do not meet the requirements set forth in 760 IAC 1-20. *(Department of Insurance; Reg 21, III; filed Mar 3, 1976, 2:55 pm: Rules and Regs. 1977, p. 224; filed Apr 10, 1986, 11:00 am: 9 IR 2058; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-20-4 Severability of provisions of rule

Authority: IC 27-1-3-7
Affected: IC 27-1-5-1

Sec. 4. SEVERABILITY. If any provision of this regulation *[760 IAC 1-20]*, or the application thereof, to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this regulation *[760 IAC 1-20]* which can be given effect without the invalid provision or application, and to that end, the provisions of this regulation *[760 IAC 1-20]* are severable. *(Department of Insurance; Reg 21,IV; filed Mar 3, 1976, 2:55 pm: Rules and Regs. 1977, p. 225; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 21. Medical Malpractice Insurance

760 IAC 1-21-1 Authority to promulgate rule; purpose of rule

Authority: IC 34-18-5-2; IC 34-18-5-4
Affected: IC 34-18-4-1

Sec. 1. This rule is promulgated under IC 34-18-5-2 and IC 34-18-5-4. The purpose of this rule is to facilitate implementation of and compliance with IC 34-18 et seq. by establishing procedures for a health care provider to establish financial responsibility by a means other than insurance. In addition, the purpose of this rule is to set the surcharge levied on health care providers in Indiana. *(Department of Insurance; Reg 22, Sec I; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 514; filed Mar 18, 1986, 10:41 a.m.: 9 IR 2057, eff Apr 18, 1986; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2874; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-21-2 Definitions

Authority: IC 34-18-5-4
Affected: IC 16-21-2; IC 25-22.5; IC 34-18-2-14

Sec. 2. As used in this rule:

(1) "Health care provider" means all health care providers as defined in IC 34-18-2-14, except physicians and hospitals.

(2) "Hospital" means a public or private institution licensed under IC 16-21-2.

(3) "Commissioner" means the commissioner of insurance of Indiana.

(4) "Physician" means an individual with an unlimited license to practice medicine under IC 25-22.5.

(Department of Insurance; Reg 22,Sec II; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 514; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2874; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-21-3 Establishment of financial responsibility by health care provider or physician

Authority: IC 34-18-5-4
Affected: IC 34-18-4-1

Sec. 3. A health care provider or a physician desiring to establish financial responsibility under IC 34-18-4-1 by a means other than insurance may do so by submitting, to the commissioner, the following:

(1) An agreement in writing, in a form and manner prescribed by the commissioner, to pay any final judgment or agreed settlement arising from claims of malpractice in accordance with the limits on liability set forth in IC 34-18-4-1(1).

(2) Filing and maintaining with the commissioner, cash or surety bonds, from a company acceptable to the commissioner, in accordance with the limits on liability set forth in IC 34-18-4-1(1) for each year in which financial responsibility is established by a means other than insurance.

(Department of Insurance; Reg 22,Sec III; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 514; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2874; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-21-4 Retention of deposit during liability

Authority: IC 34-18-5-4
Affected: IC 34-18-4-1; IC 34-18-4-2

Sec. 4. If a health care provider or physician that has established financial responsibility, in the manner set forth in section 3 of this rule, ceases practice, establishes financial responsibility by means of insurance, or decides that he or she no longer wishes to establish financial responsibility under IC 34-18, any cash or surety bond filed with the commissioner shall remain on deposit until liability ceases to exist. *(Department of Insurance; Reg 22,Sec IV; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 515; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2874; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-21-5 Financial responsibility of hospital

Authority: IC 34-18-5-4
Affected: IC 34-18-4-1; IC 34-18-5-3

Sec. 5. A hospital may establish financial responsibility for itself, its officers, agents, and employees by submitting, to the commissioner, all of the following:

(1) An agreement in writing, in a form and manner prescribed by the commissioner, to pay any final judgment or agreed settlement arising from claims of malpractice subject to the limits on liability set forth in IC 34-18-4-1(1)(A)(i) and IC 34-18-4-1(1)(A)(ii).

(2) An agreement in writing that the hospital will establish and maintain a claims management and risk management program, which program shall include, at a minimum, the following:

(A) Procedures satisfactory to the commissioner for the prompt investigation of each malpractice claim reported to the hospital to determine whether malpractice liability exists and to determine its cause.

(B) Procedures for the efficient processing, adjustment, and reasonable settlement of claims.

(C) Procedures for the defense by legal counsel of claims that cannot be adjusted or settled.

(D) Procedures to examine the cause of losses and to take action to reduce their frequency and severity, including a safety program and employee and professional training program.

The hospital may undertake such a claims management and risk management program through its own qualified personnel, or it may undertake part or all of the program through the services of qualified independent contractors.

(3) A verified financial statement that demonstrates the financial resources of the hospital are sufficient to satisfy all malpractice claims incurred by it up to the limits on liability set forth in IC 34-18-4-1(3). Notwithstanding, if the hospital is an agency of any governmental unit and desires to use the taxing power of that governmental unit to establish its financial security, it may establish financial responsibility by filing with the commissioner a copy of an ordinance or resolution of the taxing governing body of the governmental unit, authorizing the hospital to do so, and acknowledging the responsibility of the governmental unit for any judgment or settlement arising from claims of malpractice.

(4) An agreement in writing that if the hospital discontinues operation or decides to purchase insurance to establish financial responsibility under IC 34-18 et seq., the hospital will continue to be liable in the amounts set forth in subdivision (1) until liability ceases to exist.

(Department of Insurance; Reg 22,Sec V; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 515; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2875; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-21-6 Financial reserves

Authority: IC 16-9.5-2-7
Affected: IC 16-9.5-1-1; IC 16-10-1-6

Sec. 6. A health care provider that establishes financial responsibility by a means other than insurance must maintain reserves adequate to cover the possible loss and expected litigation costs in conjunction with the claim submitted against that health care provider. Such reserves must be established within 60 days after a claim is reported. *(Department of Insurance; Reg 22,Sec VI; filed Jan 27, 1977, 2:35 pm: Rules and Regs. 1978, p. 516; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-21-7 Cash deposits
Authority: IC 16-9.5-2-7
Affected: IC 16-9.5-1-1; IC 16-10-1-6

Sec. 7. Cash deposited by a health care provider under this regulation may be deposited in an interest-bearing account in any bank located in Indiana. Such a deposit must be in a joint account under the control of the Commissioner of Insurance and the health care provider. The health care provider may withdraw accrued interest from the account. *(Department of Insurance; Reg 22,Sec VII; filed Jan 27, 1977, 2:35 pm: Rules and Regs. 1978, p. 516; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-21-8 Payment into patient's compensation fund; annual surcharge
Authority: IC 34-18-5-4
Affected: IC 34-18-5-2; IC 34-18-5-3

Sec. 8. (a) The annual surcharge for a health care provider shall be one hundred percent (100%) of the cost to the health care provider for maintenance of financial responsibility.

(b) A health care provider establishing financial responsibility by means other than insurance under section 3 of this rule shall pay into the patient's compensation fund an amount equal to one hundred percent (100%) of the premium that would be charged to the health care provider by the residual malpractice insurance authority. The payment must be made each year under IC 34-18-5-3 within thirty (30) days after qualification. *(Department of Insurance; Reg 22, Sec VIII; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 516; filed Mar 18, 1986, 10:41 a.m.: 9 IR 2057, eff Apr 18, 1986; filed May 28, 1987, 4:00 p.m.: 10 IR 2298; filed Aug 13, 1991, 4:00 p.m.: 15 IR 7; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2875; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-21-9 Effective date of rule (Repealed)

Sec. 9. *(Repealed by Department of Insurance; filed May 28, 1987, 4:00 pm: 10 IR 2298)*

Rule 22. Annual Statement–Subrogation or Salvage Recovery Amounts (Repealed)
(Repealed by Department of Insurance; filed Mar 26, 1993, 5:00 p.m.: 16 IR 1949)

Rule 23. Accident and Sickness Insurance-Claim Forms

760 IAC 1-23-1 Authority to promulgate rule; effective date
Authority: IC 27-1-3-7
Affected: IC 27-8-5.5-2

Sec. 1. By authority vested in the Insurance Commissioner under the terms of I.C. 27-8-5.5-2 which became law in this state effective June 1, 1977, the following regulation *[760 IAC 1-23]* is to become effective on September 1, 1977. This action is predicated upon the need to establish uniformity of reporting data by providers of health care or treatment for the processing of health care and health insurance benefits. *(Department of Insurance; Reg 24,Sec 1; filed Aug 9, 1977, 9:50 am: Rules and Regs. 1978, p. 528; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-23-2 Approved forms
Authority: IC 27-1-3-7
Affected: IC 27-8-5.5-2

Sec. 2. All accident and sickness insurers, hospitals, medical and dental service corporations, and other prepayment organizations must accept forms approved by this Department for the administration of benefit payments.

It is the opinion of the Commissioner that the interests of the insuring public would be best served by adoption of forms developed for nationwide use by national health care provider organizations, health insurers and other prepayment organizations. Accordingly, the following forms are hereby adopted and approved for use in this state:

ATTENDING DENTIST'S STATEMENT – ADS (75), (Exhibit 1), developed under the auspices of the American Dental Association by its Task Force representing dental insurance underwriters.

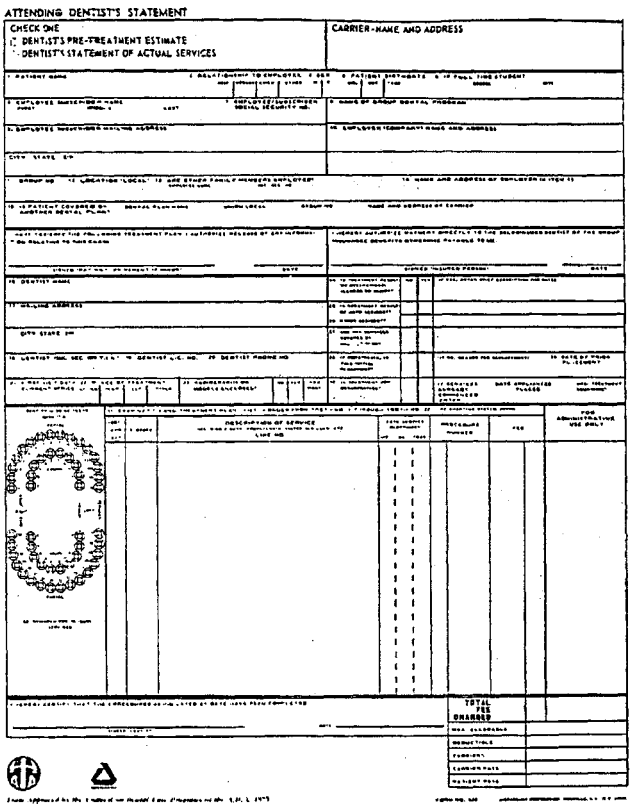
HEALTH INSURANCE CLAIM FORM – 6-74, (Exhibit II), developed under the auspices of an *[sic.]* approved by the American Medical Association by its WORK GROUP on attending physician's billing and insurance reporting forms representing health insurers.

UNIFORM HOSPITAL BILLING FORM – UB-82 HCFA-1450, (Exhibit III), developed under the auspices of the Health Care Financing Administration of the Department of Health and Human Services.

LONG-TERM DISABILITY INCOME – APS-LT/P&T DIS (75), (Exhibit IV), developed by the Standard Forms Committee of the Health Insurance Association of American Council on Consumer and Professional Relations and approved by the American Medical Association Committee on Health Care Financing.

VISION INSURANCE CLAIM FORM – VICF (75), (Exhibit V), developed by the Standard Forms Committee of the Health Insurance Association of American Council on Consumer and Professional Relations and approved by the American Optometric Association.

EXHIBIT I

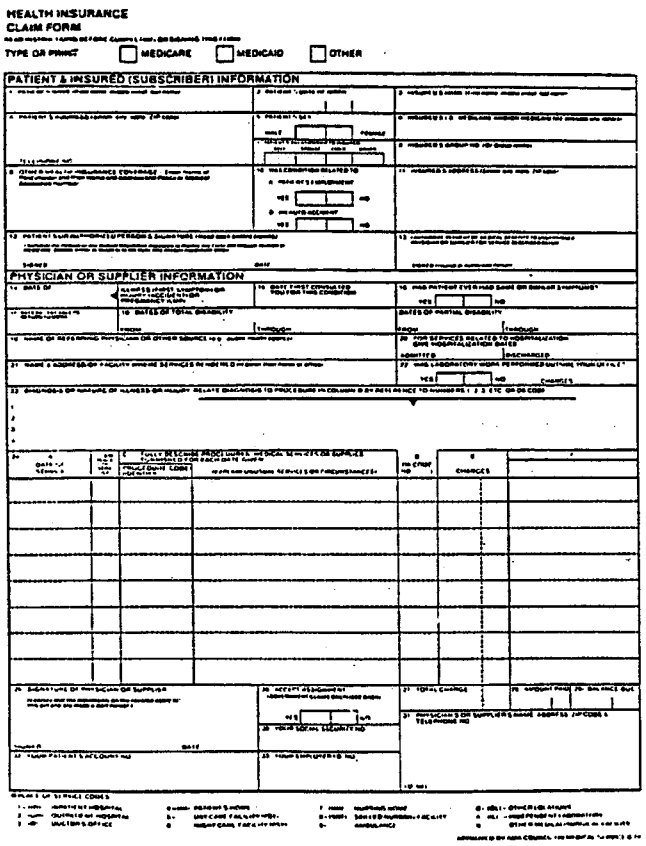

ATTENDING DENTIST'S STATEMENT

CHECK ONE
1. DENTIST'S PRE-TREATMENT ESTIMATE
2. DENTIST'S STATEMENT OF ACTUAL SERVICES

CARRIER-NAME AND ADDRESS

TOTAL FEE CHARGED

EXHIBIT II



HEALTH INSURANCE
CLAIM FORM

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ OTHER

PATIENT & INSURED (SUBSCRIBER) INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EXHIBIT II—Continued

HEALTH INSURANCE CLAIM FORM

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the carrier, if this is less than the charge submitted.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare regulations.

For services to be considered as 'incident to' a physician's professional service 1) they must be rendered under the physician's immediate personal supervision by his employee, 2) there was a covered physician's service rendered of which the other services are an integral, although incidental part, 3) they must be kinds commonly furnished in physicians' offices, and 4) the services of nonphysicians must be included on the physicians' bill.

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal laws.

MEDICAID PAYMENTS: I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles and coinsurance.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable federal or state laws.

Revised 12/77

Additional forms may be purchased from:
Order Department OP-407
American Medical Association
PO Box 821
Monroe, WI 53566

TA 1831:385-O-478: 1,00044

EXHIBIT III

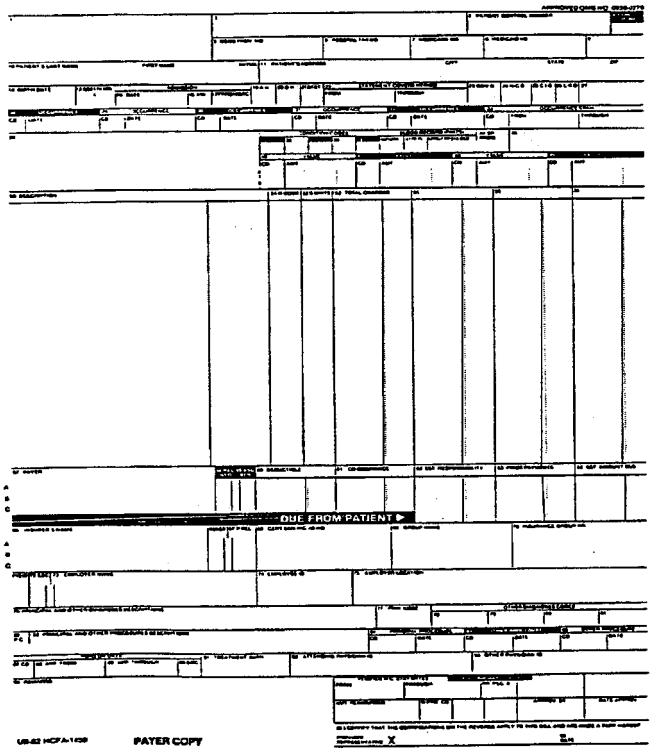


EXHIBIT III - Continued

UNIFORM BILL

NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND OR STATE LAW.

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof; appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 405.1663, 10 USC 1071 thru 1086, 32 CFR 199) and, if required by other contract regulations, is on file.
6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare purposes:

   If the patient has indicated that other health insurance or state medical assistance agency will pay part of his medical expenses and he wants information about his claim released to them upon their request, necessary authorization is on file.
8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.

   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.
9. For CHAMPUS purposes:

   This is to certify that:

   (a) the foregoing information is true, accurate, and complete;

   (b) The patient has represented that by a reported residential address greater than 40 miles distance he or she does not live within 40 miles of a military or U.S. Public Health Service medical facility, or if the patient resides within 40 miles of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or sponsor has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face of the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

ESTIMATED CONTRACT BENEFITS

EXHIBIT 1V

ATTENDING PHYSICIAN'S STATEMENT

(OPTIONAL – This space can be utilized by carriers to explain the employee's occupation; make a statement relative to eligibility; give any mailing instructions the carrier desires; make a statement that the patient is responsible for obtaining completion of the form at no expense to the Company, etc.) This space can also be used to state the purpose of the form to the doctor and make reference to specific information that would be needed to determine disability).

Name of patient _____ Date of birth ___/___/___ (Mo. Day Year)

Employer name _____ Group/Policy No. _____

1. HISTORY
   (a) When did symptoms first appear or accident happen? ... Mo. _____ Day _____ 19 ___
   (b) Date patient ceased work because of disability ..... Mo. _____ Day _____ 19 ___
   (c) Has patient ever had same or similar condition? ..... Yes ☐ No ☐ *If "Yes" state when and describe* .....
   (d) Is condition due to injury or sickness arising out of patient's employment? Yes ☐ No ☐ Unknown ☐
   (e) Names and addresses of other treating physicians .....

2. DIAGNOSIS (including any complications)
   (a) Date of last examination ..... Mo. _____ Day _____ 19 ___
   (b) Diagnosis (including any complications)
   (c) Subjective symptoms
   (d) Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)

3. DATES OF TREATMENT
   (a) Date of first visit ..... Mo. _____ Day _____ 19 ___
   (b) Date of last visit ..... Mo. _____ Day _____ 19 ___
   (c) Frequency ..... Weekly ☐ Monthly ☐ Other (Specify) ☐ _____

4. NATURE OF TREATMENT (including Surgery and medications prescribed, if any)

5. PROGRESS
   (a) Has patient ..... Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed? ☐
   (b) Is patient ..... Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined? ☐
   (c) Has patient been hospital confined? Yes ☐ No ☐ If yes, give Name and Address of Hospital _____ Confined from _____ through _____

6. CARDIAC (If Applicable)
   (a) Functional capacity ..... Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐
   (American Heart Ass'n.) Class 3 (Marked limitation) ☐ Class 4 (Complete limitation) ☐
   (b) Blood Pressure (last visit) ..... _____ / _____ SYSTOLIC / DIASTOLIC

EXHIBIT IV—Continued

7. PHYSICAL IMPAIRMENT ("as defined in Federal Dictionary of Occupational Titles)

- ☐ Class 1 — No limitation of functional capacity; capable of heavy work* No restrictions. (0-10%)
- ☐ Class 2 — Medium manual activity* (15-30%)
- ☐ Class 3 — Slight limitation of functional capacity; capable of light work* (35-55%)
- ☐ Class 4 — Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)
- ☐ Class 5 — Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%)
- ☐ Remarks:

8. MENTAL/NERVOUS IMPAIRMENT (if applicable)

(a) Please define "stress" as it applies to this claimant.

(b) What stress and problems in interpersonal relations has claimant had on job?

- ☐ Class 1 — Patient is able to function under stress and engage in interpersonal relations (no limitations)
- ☐ Class 2 — Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- ☐ Class 3 — Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- ☐ Class 4 — Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- ☐ Class 5 — Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
- ☐ Remarks:

Do you believe the patient is competent to endorse checks and direct the use or the proceeds thereof? Yes ☐ No ☐

9. PROGNOSIS

	PATIENT'S JOB	ANY OTHER WORK
(a) Is patient now totally disabled?	Yes ☐ No ☐	Yes ☐ No ☐
(b) What duties of patient's job is he/she incapable of performing?		
Do you expect a fundamental or marked change in the future?	Yes ☐ No ☐	Yes ☐ No ☐
(1) If yes, when will patient recover sufficiently to perform duties	___/___/___ (Mo. Day Yr.) 1 Mo. ☐ 3-6 Mos. ☐ 1-2 Mos. ☐ Never ☐	___/___/___ (Mo. Day Yr.) 1 Mo. ☐ 3-6 Mos. ☐ 1-3 Mos. ☐ Never ☐
(2) If no, please explain		

10. REHABILITATION

(a) Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.) Yes ☐ No ☐

(b) Can present job be modified to allow for handling with impairment? Yes ☐ No ☐

	PATIENT'S JOB	ANY OTHER WORK
(c) When could trial employment commence?	___/___/___ (Mo. Day Yr.) Full-time ☐ Part-time ☐	___/___/___ (Mo. Day Yr.) Full-time ☐ Part-time ☐

(d) Would vocational counseling and/or retraining be recommended? Yes ☐ No ☐

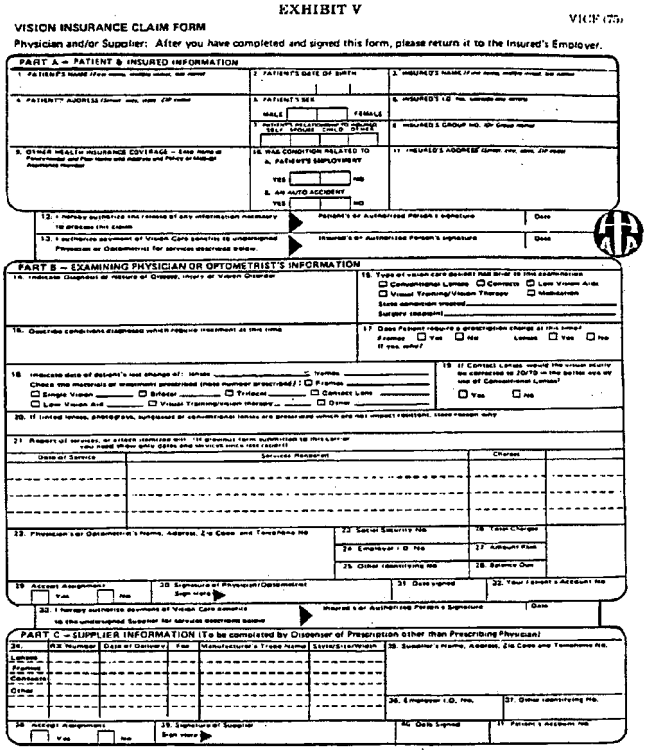
11. REMARKS

Name (Attending Physician) Print _____ Degree _____ Telephone _____

Street Address _____ City or Town _____ State or Province _____ Zip Code _____

Signature _____ Date _____

EXHIBIT V


VISION INSURANCE CLAIM FORM

Physician and/or Supplier: After you have completed and signed this form, please return it to the Insured's Employer.

PART A – PATIENT & INSURED INFORMATION

PART B – EXAMINING PHYSICIAN OR OPTOMETRIST'S INFORMATION

PART C – SUPPLIER INFORMATION (To be completed by Dispenser of Prescription other than Prescribing Physician)

(Department of Insurance; Reg 24, Sec 2; filed Aug 9, 1977, 9:50 am: Rules and Regs. 1978, p. 529; filed Jan 4, 1988, 2:30 pm: 11 IR 1577; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-23-3 Modification of forms

Authority: IC 27-1-3-7
Affected: IC 27-8-5.5-2

Sec. 3. Statements, instructions, or reports, such as those which are normally completed by claimants and policyholders, and needed in the administration of benefit payments, but not requiring information from providers, may be included on the reverse side of any of the approved forms. The approved forms shall not be changed by the addition of data elements or questions; however, the name and/or identifying symbol of the insuring or prepayment organization and/or the group policyholder and/or the professional organization furnishing the form, may be imprinted in the space provided.

Unneeded data elements or sections may be deleted and the space closed-up, except as follows:

Unneeded elements in the "PATIENT AND INSURED (SUBSCRIBER) INFORMATION" section of the Health Insurance Claim Form-(6-74), (Exhibit II) *[760 IAC 1-23-2]*, may be deleted and the space closed; however, unneeded items in the "PHYSICIAN OR SUPPLIER INFORMATION" section must be shaded-out so that the dimensions of this section and the sequence of the elements are not altered. Further, this section must be positioned on an 8 1/2 × 11 sheet of paper so that the forms of two or more insuring or prepayment organizations may be completed together by the insertion of carbon paper between them. *(Department of Insurance; Reg 24,Sec 3; filed Aug 9, 1977, 9:50 am: Rules and Regs. 1978, p. 529; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-23-4 Additional information; approval of non-standard forms

Authority: IC 27-1-3-7
Affected: IC 27-8-5.5-2

Sec. 4. This regulation does not prohibit an insurer, service corporation or prepayment organization from requesting additional information from a provider of health care or treatment when such information is necessary for the proper administration of determining benefit payments. Further, if an insurer or prepayment organization needs a provider report form which differs in some respects from its approved counterpart, such forms shall be submitted to the Insurance Department for approval along with the reasons for the deviations. *(Department of Insurance; Reg 24,Sec 4; filed Aug 9, 1977, 9:50 am: Rules and Regs. 1978, p. 530; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-23-5 Revision of approved forms

Authority: IC 27-1-3-7
Affected: IC 27-8-5.5-2

Sec. 5. It is anticipated that reporting forms herein adopted for use in this state will require periodic revision resulting in new editions. In such event, the new editions will be acceptable for use in this state; provided, (1) such have been approved by the appropriate health care or treatment provider groups and organization as set forth in Section 2 *[760 IAC 1-23-2]* of this Regulation, and (2) such new editions have been filed with this Department. *(Department of Insurance; Reg 24,Sec 5; filed Aug 9, 1977, 9:50 am: Rules and Regs. 1978, p. 530; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 24. Life Insurance Solicitation

760 IAC 1-24-1 Authority to promulgate rule; effective date

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 1. Authority. By authority vested in the Insurance Commissioner under the terms of I.C. 27-1-3-7, the following regulation is to become effective six (6) months after the promulgation of this regulation *[760 IAC 1-24]*. *(Department of Insurance; Reg 25, Sec 1; filed Dec 26, 1978, 11:10 am: 2 IR 165; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-24-2 Purpose of rule

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 2. Purpose. (A) The purpose of this regulation *[760 IAC 1-24]* is to require insurers to deliver to purchasers of life insurance information which will improve the buyer's ability to select the most appropriate plan of life insurance for his needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration and improve the ability of the buyer to evaluate the relative costs of similar plans of life insurance.

(B) This regulation *[760 IAC 1-24]* does not prohibit the use of additional material which is not in violation of this regulation *[760 IAC 1-24]* or any other state statute or regulation. *(Department of Insurance; Reg 25, Sec 2; filed Dec 26, 1978, 11:10 am: 2 IR 165; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-24-3 Applicability of rule

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 3. Scope. (A) Except as hereafter exempted, this regulation *[760 IAC 1-24]* shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. This regulation *[760 IAC 1-24]* shall apply to any issuer of life insurance contracts including fraternal benefit societies.

(B) Unless otherwise specifically included, this regulation *[760 IAC 1-24]* shall not apply to:

(1) Annuities
(2) Credit life insurance
(3) Group life insurance

(4) Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA).

(5) Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.

(Department of Insurance; Reg 25, Sec 3; filed Dec 26, 1978, 11:10 am: 2 IR 165; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-24-4 Definitions

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 4. Definitions. For the purpose of this regulation *[760 IAC 1-24]*, the following definitions shall apply:

(A) Buyer's Guide. A Buyer's Guide is a document which contains, and is limited to, the language contained in the Appendix *[760 IAC 1-24-9]* to this regulation or language approved by the Commissioner of Insurance.

(B) Cash Dividend. A Cash Dividend is the current illustrated dividend which can be applied toward payment of the gross premium.

(C) Equivalent Level Annual Dividend. The Equivalent Level Annual Dividend is calculated by applying the following steps:

(1) Accumulate the annual cash dividends at five percent interest compounded annually to the end of the tenth and twentieth policy years.

(2) Divide each accumulation of Step (1) *[subsection (C)(1) of this section]* by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in Step (1) *[subsection (C)(1) of this section]* over the respective periods stipulated in Step (1) *[subsection (C)(1) of this section]*. If the period is ten years, the factor is 13.207 and if the period is twenty years, the factor is 34.719.

(3) Divide the results of Step (2) *[subsection (C)(2) of this section]* by the number of thousands of the Equivalent Level Death Benefit to arrive at the Equivalent Level Annual Dividend.

(D) Equivalent Level Death Benefit. The Equivalent Level Death Benefit of a policy or term life insurance rider is an amount calculated as follows:

(1) Accumulate the guaranteed amount payable upon death, regardless of the cause of death, at the beginning of each policy year for ten and twenty years at five per cent interest compounded annually to the end of the tenth and twentieth policy years respectively.

(2) Divide each accumulation of Step (1) *[subsection (D)(1) of this section]* by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in Step (1) *[subsection (D)(1) of this section]* over the respective periods stipulated in Step (1) *[subsection (D)(1) of this section]*. If the period is ten years, the factor is 13.207 and if the period is twenty years, the factor is 34.719.

(E) Generic Name. Generic Name means a short title which is descriptive of the premium and benefit patterns of a policy or rider.

(F) Life Insurance Cost Indexes.

(1) Life Insurance Surrender Cost Index. The Life Insurance Surrender Cost Index is calculated by applying the following steps:

(a) Determine the guaranteed cash surrender value, if any, available at the end of the tenth and twentieth policy years.

(b) For participating policies, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual Cash Dividends at five per cent interest compounded annually to the end of the period selected and add this sum to the amount determined in Step (a) *[subsection (F)(1)(a) of this section]*.

(c) Divide the result of Step (b) *[subsection (F)(1)(b) of this section]* (Step (a) *[subsection (F)(1)(a) of this section]* for guaranteed-cost policies) by an interest factor that converts it into an equivalent level amount that, if paid at the beginning of each year, would accrue to the value in Step (b) *[subsection (F)(1)(b) of this section]* (Step (a) *[subsection (F)(1)(a) of this section]* for guaranteed-cost policies) over the respective periods stipulated in Step (a) *[subsection (F)(1)(a) of this section]*. If the period is ten years, the factor is 13.207 and if the period is twenty years, the factor is 34.719.

(d) Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider

at five per cent interest compounded annually to the end of the period stipulated in Step (a) *[subsection (F)(1)(a) of this section]* and dividing the result by the respective factors stated in Step (c) *[subsection (F)(1)(c) of this section]* this amount is the annual premium payable for a level premium plan).

(e) Subtract the result of Step (c) *[subsection (F)(1)(c) of this section]* from Step (d) *[subsection (F)(1)(d) of this section]*.

(f) Divide the result of Step (e) *[subsection (F)(1)(e) of this section]* by the number of thousands of the Equivalent Level Death Benefit to arrive at the Life Insurance Surrender Cost Index.

(2) Life Insurance Net Payment Cost Index. The Life Insurance Net Payment Cost Index is calculated in the same manner as the comparable Life Insurance Cost Index except that the cash surrender value and any terminal dividend are set at zero.

(G) Policy Summary. For the purpose of this regulation, Policy Summary means a written statement describing the elements of the policy including but not limited to:

(1) A prominently placed title as follows: STATEMENT OF POLICY COST AND BENEFIT INFORMATION.

(2) The name and address of the insurance agent, or, if no agent is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the Policy Summary.

(3) The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written.

(4) The Generic Name of the basic policy and each rider.

(5) The following amounts, where applicable, for the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including, but not necessarily limited to, the years for which Life Insurance Cost Indexes are displayed and at least one age from sixty through sixty-five or maturity whichever is earlier:

(a) The annual premium for the basic policy.

(b) The annual premium for each optional rider.

(c) Guaranteed amount payable upon death, at the beginning of the policy year regardless of the cause of death other than suicide, or other specifically enumerated exclusions, which is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately.

(d) Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider.

(e) Cash Dividends at current scale payable at the end of the year with values shown separately for the basic policy and each rider. (Dividends need not be displayed beyond the twentieth policy year.)

(f) Guaranteed endowment amounts payable under the policy which are not included under guaranteed cash surrender values above.

(6) The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is variable, the Policy Summary shall state the maximum annual percentage rate.

(7) Life Insurance Cost Indexes for ten and twenty years but in no case beyond the premium paying period. Separate indexes are displayed for the basic policy and for each optional term life insurance rider. Such indexes need not be included for optional riders which are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months and guaranteed insurability benefits nor for the basic policies or optional riders covering more than one life.

(8) The Equivalent Level Annual Dividend, in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which Life Insurance Cost Indexes are displayed.

(9) A Policy Summary which includes dividends shall also include a statement that dividends are based on the company's current dividend scale and are not guaranteed, in addition to a statement in close proximity to the Equivalent Level Annual Dividend as follows: An explanation of the intended use of the Equivalent Level Annual Dividend is included in the Life Insurance Buyer's Guide.

(10) A statement in close proximity to the Life Insurance Cost Indexes as follows: An explanation of the intended use of these indexes is provided in the Life Insurance Buyer's Guide.

(11) The date on which the Policy Summary is prepared.

The Policy Summary must consist of a separate document. All information required to be disclosed must be set out in such a manner as to not minimize or render any portion of it obscure. Any amounts which remain level for two or more years of the policy may

be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in item 5 of this section *[subsection (G)(5) of this section]* shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space. *(Department of Insurance; Reg 25, Sec 4; filed Dec 26, 1978, 11:10 am: 2 IR 166; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-24-5 Disclosure requirements

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 5. Disclosure Requirements. (A) The insurer shall provide, to all prospective purchasers, a Buyer's Guide and a Policy Summary prior to accepting the applicant's initial premium or premium deposit, unless the policy for which application is made contains an unconditional refund provision of at least ten days or unless the Policy Summary contains such an unconditional refund offer, in which event the Buyer's Guide and Policy Summary must be delivered with the policy or prior to delivery of the policy.

(B) The insurer shall provide a Buyer's Guide and a Policy Summary to any prospective purchaser upon request.

(C) In the case of policies whose Equivalent Level Death Benefit does not exceed $5,000, the requirement for providing a Policy Summary will be satisfied by delivery of a written statement containing the information described in Section 4(G), items 2, 3, 4, 5a, 5b, 6, 7, 10, and 11 *[760 IAC 1-24-4(G)(2), (G)(3), (G)(4), (G)(5)(a), (G)(5)(b), (G)(6), (G)(7), (G)(10), and (G)(11)]*. *(Department of Insurance; Reg 25, Sec 5; filed Dec 26, 1978, 11:10 am: 2 IR 167; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-24-6 File of forms used; presentation to prospective purchaser; annual premium defined

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 6. General Rules. (A) Each insurer shall maintain at its home office or principal office, a complete file containing one copy of each form authorized by the insurer for use pursuant to this regulation. Such file shall contain one copy of each authorized form for a period of three years following the date of its last authorized use.

(B) An agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company whish he is representing to the buyer. In sales situations in which an agent is not involved, the insurer shall identify its full name.

(C) Terms such as financial planner, investment advisor, financial consultant, or financial counseling shall not be used in such a way as to imply that the insurance agent is generally engaged in an advisory business in which compensation is unrelated to sales unless such is actually the case.

(D) Any reference to policy dividends must include a statement that dividends are not guaranteed.

(E) A system or presentation which does not recognize the time value of money through the use of appropriate interest adjustments shall not be used for comparing the cost of two or more life insurance policies. Such a system may be used for the purpose of demonstrating the cash-flow pattern of a policy if such presentation is accompanied by a statement disclosing that the presentation does not recognize that, because of interest, a dollar in the future has less value than a dollar today.

(F) A presentation of benefits shall not display guaranteed and non-guaranteed benefits combined in a single sum unless the guaranteed portion is shown separately in close proximity thereto.

(G) A statement regarding the use of the Life Insurance Cost Indexes shall include an explanation to the effect that the indexes are useful only for the comparison of the relative costs of two or more similar policies.

(H) A Life Insurance Cost Index which reflects dividends or an Equivalent Level Annual Dividend shall be accompanied by a statement that it is based on the company's current dividend scale and is not guaranteed.

(I) For the purposes of this regulation *[760 IAC 1-24]*, the annual premium for a basic policy or rider, for which the company reserves the right to change the premium, shall be the maximum annual premium. *(Department of Insurance; Reg 25, Sec 6; filed Dec 26, 1978, 11:10 am: 2 IR 167; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-24-7 Failure to deliver buyer's guide or policy summary

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 7. Failure to Comply. Failure of an insurer to provide or deliver a Buyer's Guide, or a Policy Summary as provided in Section 5 *[760 IAC 1-24-5]* shall constitute an omission which misrepresents the benefits, advantages, conditions or terms of an insurance policy. *(Department of Insurance; Reg 25, Sec 7; filed Dec 26, 1978, 11:10 am: 2 IR 168; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-24-8 Effective date of rule

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 8. Effective Date. This rule *[760 IAC 1-24]* shall apply to all solicitations of life insurance which commence on or after promulgation six (6) months subsequent to promulgation of the regulation. *(Department of Insurance; Reg 25, Sec 8; filed Dec 26, 1978, 11:10 am: 2 IR 168; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-24-9 Life insurance buyer's guide

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7

Sec. 9. Appendix. Life Insurance Buyer's Guide. The face page of the Buyer's Guide shall read as follows:

Life Insurance Buyer's Guide

This guide can show you how to save money when you shop for life insurance. It helps you to:

–Decide how much life insurance you should buy,

–Decide what kind of life insurance policy you need, and

–Compare the cost of similar life insurance policies.

Prepared by the National Association of Insurance Commissioners

Reprinted by (Company Name)

(Month and year of printing)

The Buyer's Guide shall contain the following language at the bottom of page 2:

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers. You are urged to use this Guide in making a life insurance purchase.

This Guide Does not Endorse Any Company or Policy. The remaining text of the Buyer's Guide shall begin on page 3 as follows:

Buying Life Insurance. When you buy life insurance, you want a policy which fits your needs without costing too much. Your first step is to decide how much you need, how much you can afford to pay and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by using the life insurance cost indexes which are described in this guide. A good life insurance agent or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand what kinds are available. If one kind does not seem to fit your needs, ask about the other kinds which are described in this guide. If you feel that you need more information than is given here, you may want to check with a life insurance agent or company or books on life insurance in your public library.

Choosing the Amount. One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses of final illnesses, paying taxes, mortgages or other debts. It can also provide income for your family's living expenses, educational costs and other future expenses. Your new policy should come as close as you can afford to making up the difference between (1) what your dependents would have if you were to die now, and (2) what they would actually need.

Choosing the Right Kind. All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds of life insurance.

(1) Term insurance

(2) Whole life insurance

(3) Endowment insurance

Remember, no matter how fancy the policy title or sales presentation might appear, all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the agent or company if it combines more than one kind of life insurance. The following is a brief description of the three basic kinds:

Term Insurance. Term insurance is death protection for a "term" of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some term insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued.

Some term insurance policies are also "convertible". This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Whole Life Insurance. Whole life insurance gives death protection for as long as you live. The most common type is called "straight life" or "ordinary life" insurance, for which you pay the same premiums for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop "cash values" which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called "nonforfeiture benefits". This refers to benefits you do not lose (or "forfeit") when you stop paying premiums. The amount of these benefits depends on the kind of policy you have, its size, and how long you have owned it.

A policy with cash values may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money which you owe on a policy loan would be deducted from the benefits if you were to die, or from the cash value if you were to stop paying premiums.

Endowment Insurance. An endowment insurance policy pays a sum or income to you–the policyholder–if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than for the same amount of whole life insurance. Thus endowment insurance gives you the least amount of death protection.

Finding a Low Cost Policy. After you have decided what kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the "Surrender Cost Index" and the other is the "Net Payment Cost Index". It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.

What is Cost? "Cost" is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called "participating" policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called "guaranteed cost" or "non-participating" policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What are Cost Indexes? In order to compare the cost of policies, you need to look at:

(1) Premiums

(2) Cash Values

(3) Dividends

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and to subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance agents and companies:

(1) Life Insurance Surrender Cost Index. This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.

Life Insurance Net Payment Cost Index. This index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the Equivalent Level Annual Dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy's Equivalent Level Annual Dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a non-participating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the non-participating policy will not change.

How Do I Use Cost Indexes? The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

(1) Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.

(2) Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a “Shopper's Guide” tells you that one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys.

(3) Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its agent. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.

(4) In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or agent will provide service in the future, to you as a policyholder.

(5) These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for awhile, in favor of a new one. If such a replacement is suggested, you should ask for information from the company which issued the old policy before you take action.

Important Things to Remember–A Summary. The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums most closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy. If you compare Surrender Cost Indexes and Net Payment Cost Indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. REMEMBER, LOOK FOR POLICIES WITH LOWER COST INDEX NUMBERS. A good life insurance agent can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you make cost comparisons of similar policies.

Don't buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you may get little or nothing back, and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the agent or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and

responsibilities. *(Department of Insurance; Reg 25, Appendix; filed Dec 26, 1978, 11:10 am: 2 IR 168; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 25. Variable Life Insurance (Repealed)

(Repealed by Department of Insurance; filed Mar 29, 1985, 1:46 pm: 8 IR 1026)

Rule 26. Cash Value Benefits in Health Insurance Policies (Repealed)

(Repealed by Department of Insurance; filed Mar 26, 1993, 5:00 p.m.: 16 IR 1949)

Rule 27. Examination and License Fee

760 IAC 1-27-1 Authority

Authority: IC 25-1-8
Affected: IC 25-1-8-2

Sec. 1. Authority. This Regulation *[760 IAC 1-27]* is promulgated by the Commissioner of the Indiana Department of Insurance pursuant to authority set forth in IC 25-1-8-2. *(Department of Insurance; 760 IAC 1-27-1; filed Oct 6, 1981, 3:45 pm: 4 IR 2418; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-27-2 Purpose

Authority: IC 25-1-8
Affected: IC 27-1-15.5-4; IC 27-1-25-11; IC 27-1-27-4

Sec. 2. Purpose. The purpose of this Regulation *[760 IAC 1-27]* is: (a) To establish a fee schedule for examinations required by the Department of Insurance in the licensing of insurance agents, limited insurance representatives, surplus lines insurance agents, insurance consultants, and public adjusters;

(b) To establish a fee schedule for the issuance of licenses to insurance agents, limited insurance representatives, surplus lines insurance agents, and insurance consultants; for certificates of registration to insurance administrators and for certificates of authority to public adjusters. *(Department of Insurance; 760 IAC 1-27-2; filed Oct 6, 1981, 3:45 pm: 4 IR 2418; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-27-3 License examination fees (Repealed)

Sec. 3. *(Repealed by Department of Insurance; filed Sep 5, 1996, 11:00 a.m.: 20 IR 18)*

760 IAC 1-27-4 License fees

Authority: IC 27-1-15.5-7.7; IC 27-1-15.5-16; IC 27-1-27-4
Affected: IC 27-1-15.5-4; IC 27-1-15.5-7

Sec. 4. (a) The following fees shall be charged by and paid to the department of insurance for the following licenses and license renewals:

(1) A fee of twenty dollars ($20) biennially for each license issued to an insurance agent or to a limited insurance representative.

(2) A fee of twenty dollars ($20) annually for a license issued to an insurance consultant.

(3) A fee of twenty dollars ($20) annually for a license issued to a surplus lines insurance agent.

(4) A fee of fifty dollars ($50) annually for a certificate of registration issued to an insurance administrator.

(5) A fee of twenty dollars ($20) annually for a certificate of authority issued to a public adjuster.

(b) The fees set forth in subsection (a) are effective for any applicable license, certificate of registration, or certificate of authority issued or renewed on or after January 1, 1996. *(Department of Insurance; 760 IAC 1-27-4; filed Oct 6, 1981, 3:45 p.m.: 4 IR 2418; filed May 7, 1990, 5:00 p.m.: 13 IR 1720, eff Jul 1, 1990; filed Sep 5, 1996, 11:00 a.m.: 20 IR 15; readopted filed Sep*

14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-27-5 Separability
Authority: IC 25-1-8
Affected: IC 27-1-15.5-4; IC 27-1-25-11; IC 27-1-27-4

Sec. 5. Separability. If any provision of this Regulation *[760 IAC 1-27]* shall be held invalid, the remainder of the Regulation *[760 IAC 1-27]* shall not be affected thereby. *(Department of Insurance; 760 IAC 1-27-5; filed Oct 6, 1981, 3:45 pm: 4 IR 2418; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 28. Medicare Supplement Insurance (Repealed)
(Repealed by Department of Insurance; filed May 1, 1990, 10:40 a.m.: 13 IR 1720)

Rule 29. Nursing Home Insurance Policies (Repealed)
(Repealed by Department of Insurance; filed Jul 18, 1996, 9:00 a.m.: 19 IR 3466)

Rule 30. Credit in Annual Statements for Reinsurance Ceded; Limitation of Risks Applicable to Companies Writing Class II and Class III Insurance Risks (Repealed)
(Repealed by Department of Insurance; filed Nov 14, 1994, 9:50 a.m.: 18 IR 878)

Rule 31. Arson Investigation Financial Assistance Fund and Arson Protection and Education Fund
NOTE: This rule was promulgated jointly with the State Fire Marshal and also appears at 650 IAC 14-2.

760 IAC 1-31-1 Authority
Authority: IC 27-1-3-7
Affected: IC 27-1-3

Sec. 1. 760 IAC 1-31 is promulgated jointly by the state fire marshal (650 IAC 14-2) and the state insurance commissioner (760 IAC 1-31) pursuant to authority set forth in IC 22-11-5-25(e) and IC 22-11-5-26(e) *[IC 22-11-5-25 and IC 22-11-5-26 were repealed by P.L.245-1987, SECTION 22, effective July 1, 1987.]*. *(Department of Insurance; 760 IAC 1-31-1; filed Jan 27, 1984, 2:49 pm: 7 IR 697; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-31-2 Purpose
Authority: IC 27-1-3-7
Affected: IC 27-1-3

Sec. 2. The purpose of 760 IAC 1-31 is to establish a governing committee to oversee the distribution of monies from the arson investigation financial assistance fund and the arson protection and education fund. *(Department of Insurance; 760 IAC 1-31-2; filed Jan 27, 1984, 2:49 pm: 7 IR 697; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-31-3 Governing committee
Authority: IC 27-1-3-7
Affected: IC 27-1-3

Sec. 3. (a) The state fire marshal and the state insurance commissioner shall jointly appoint a committee of seven (7) persons to act as a governing committee for the arson investigation financial assistance fund and the arson protection and education fund. The governing committee shall consist of one (1) representative from each of the following:
(1) police agency
(2) paid fire service
(3) volunteer fire service

(4) Indiana Insurance Institute
(5) Indiana School Board Association
(6) prosecutors' association
(7) sheriffs' association

(b) The term of the committee members shall be staggered, with each member being appointed for a period of three (3) years, except that in the first year of existence two (2) members shall be appointed for a period of one (1) year and two (2) members shall be appointed for a period of two (2) years.

(c) The governing committee shall elect a chairman from its membership annually. The state fire marshal and the state insurance commissioner shall serve as ex officio non voting members of the governing committee. The state fire marshal shall also serve as the chief administrative officer and shall implement policy and oversee disbursements from the arson investigation financial assistance fund and arson protection and education fund, as directed by the governing committee.

(d) Should a vacancy occur on the governing board, the state fire marshal and the state insurance commissioner shall jointly appoint a successor within a period of thirty (30) dyas *[sic.]* to fill the unexpired term. *(Department of Insurance; 760 IAC 1-31-3; filed Jan 27, 1984, 2:49 pm: 7 IR 697; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-31-4 Duties of the governing committee

Authority: IC 27-1-3-7
Affected: IC 27-1-3

Sec. 4. The governing committee shall perform the following duties:

(1) They shall prescribe a simple form for application.
(2) They shall review each application and approve grants with no more than ten (10) percent of each fund going to any one county, or the Indiana state police in any appropriation year, except by unamimous *[sic.]* vote of the committee.
(3) They shall meet when necessary at the discretion of the chairman, but not less than two (2) times a year.
(4) Applicants shall be given the right to appear before the committee to justify their request.
(5) Set procedure for applicant to report on the progress of use of funds.

(Department of Insurance; 760 IAC 1-31-4; filed Jan 27, 1984, 2:49 pm: 7 IR 697; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-31-5 Expenses

Authority: IC 27-1-3-7
Affected: IC 27-1-3

Sec. 5. The members of the committee shall receive per diem and mileage allowance for each day they are engaged in their official duties, an amount as prescribed by the state budget agency. This expense shall be charged equally to each fund. *(Department of Insurance; 760 IAC 1-31-5; filed Jan 27, 1984, 2:49 pm: 7 IR 697; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-31-6 Separability

Authority: IC 27-1-3-7
Affected: IC 27-1-3

Sec. 6. If any provision of 760 IAC 1-31 shall be held invalid, the remainder of 760 IAC 1-31, to the extent possible, shall not be affected thereby. *(Department of Insurance; 760 IAC 1-31-6; filed Jan 27, 1984, 2:49 pm: 7 IR 697; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 32. Blended Mortality Tables

760 IAC 1-32-1 Authority to promulgate rule

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7; IC 27-1-12-7; IC 27-1-12-10

Sec. 1. This rule *[760 IAC 1-32]* is promulgated by the commissioner of insurance pursuant to IC 27-1-3-7, IC 27-1-12-7(dd)(8F), and IC 27-1-12-10(2)(a)(iii) of the Indiana insurance laws. *(Department of Insurance; 760 IAC 1-32-1; filed Jun 28, 1984, 12:46 pm: 7 IR 1928, eff Aug 1, 1984; filed Oct 16, 1985, 2:18 pm: 9 IR 516; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-32-2 Purpose of rule

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7

Sec. 2. The purpose of this rule *[760 IAC 1-32]* is to permit individual life insurance policies to provide the same cash surrender values and paid-up nonforfeiture benefits to both men and women and, for policies providing the same cash surrender values and paid-up nonforfeiture benefits to both men and women, to permit minimum valuation standards which are the same for both men and women. *(Department of Insurance; 760 IAC 1-32-2; filed Jun 28, 1984, 12:46 pm: 7 IR 1928, eff Aug 1, 1984; filed Oct 16, 1985, 2:18 pm: 9 IR 516; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-32-3 Definitions

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7; IC 27-1-12-10

Sec. 3. (a) "1980 CSO Table, with or without Ten-Year Select Mortality Factors" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Standard Ordinary Mortality Table, with or without Ten-Year Select Mortality Factors.

(b) "1980 CSO Table (M), with or without Ten-Year Select Mortality Factors" means that mortality table consisting of the rates of mortality for male lives from the 1980 CSO Table, with or without Ten-Year Select Mortality Factors.

(c) "1980 CSO Table (F), with or without Ten-Year Select Mortality Factors" means that mortality table consisting of the rates of mortality for female lives from the 1980 CSO Table, with or without Ten-Year Select Mortality Factors.

(d) "1980 CET Table" means that mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Extended Term Insurance Table.

(e) "1980 CET Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 1980 CET Table.

(f) "1980 CET Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 1980 CET Table.

(g) "1980 CSO and 1980 CET Smoker and Nonsmoker Mortality Tables" mean the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the 1980 CSO and 1980 CET Mortality Tables by the Society of Actuaries Task Force on Smoker/Nonsmoker Mortality and adopted by the NAIC in December 1983.

(h) "Operative date" for a policy form means that date, after the election date described below, on which the form is filed with this department.

NOTE: A company elects to use 1980 CSO Mortality Tables in Indiana by filing an election letter with the department, said letter including an election date and providing that all company filings of any policy forms submitted after the election date shall utilize 1980 CSO Tables. *(Department of Insurance; 760 IAC 1-32-3; filed Jun 28, 1984, 12:46 pm: 7 IR 1928, eff Aug 1, 1984; errata, 7 IR 2381; filed Jul 16, 1987, 3:20 pm: 10 IR 2703; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-32-4 Acceptable tables

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7; IC 27-1-12-10

Sec. 4. For any policy of insurance on the life of either a male or female insured delivered or issued for delivery in this state after the operative date of IC 27-1-12-7(dd)(11) for that policy form,

(1) a mortality table which is a blend of the 1980 CSO Table (M) and the 1980 CSO Table (F) with or without Ten-Year Select Mortality Factors may at the option of the company be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors, and

(2) a mortality table which is of the same blend as used in (1) but applied to form a blend of the 1980 CET Table (M) and the 1980 CET Table (F) may at the option of the company be substituted for the 1980 CET Table

for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. For any policy using one of the acceptable tables, the same acceptable table may be used in determining the minimum standard of valuation for that policy.

The following tables will be considered as the basis for acceptable tables:

(A) 100% Male 0% Female for tables to be designated as the "1980 CSO-A" and "1980 CET-A" tables.

(B) 80% Male 20% Female for tables to be designated as the "1980 CSO-B" and "1980 CET-B" tables.

(C) 60% Male 40% Female for tables to be designated as the "1980 CSO-C" and "1980 CET-C" tables.

(D) 50% Male 50% Female for tables to be designated as the "1980 CSO-D" and "1980 CET-D" tables.

(E) 40% Male 60% Female for tables to be designated as the "1980 CSO-E" and "1980 CET-E" tables.

(F) 20% Male 80% Female for tables to be designated as the "1980 CSO-F" and "1980 CET-F" tables.

(G) 0% Male 100% Female for tables to be designated as the "1980 CSO-G" and "1980 CET-G" tables.

Tables A and G are not to be used with respect to policies issued on or after January 1, 1985, except where the proportion of persons insured is anticipated to be 90% or more of one sex or the other except for certain policies converted from group insurance. Such group conversions issued on or after January 1, 1986, must use mortality tables based on the blend of lives by sex expected for such policies if such group conversions are considered as extensions of the Norris decision. This consideration has not been clearly defined by court or legislative action in all jurisdictions. The values of 1000qx for blended Tables B, C, D, E and F are shown in Appendix I (760 IAC 1-32-8). The letter in Appendix II (760 IAC 1-32-9) states the method by which selection factors may be obtained. Table A is the same as 1980 CSO Table (M) and 1980 CET Table (M) and Table G is the same as 1980 CSO Table (F) and 1980 CET Table (F). *(Department of Insurance; 760 IAC 1-32-4; filed Jun 28, 1984, 12:46 pm: 7 IR 1929, eff Aug 1, 1984; errata, 7 IR 2381; filed Oct 16, 1985, 2:18 pm: 9 IR 516; filed Jul 16, 1987, 3:20 pm: 10 IR 2704; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-32-4.1 Alternate rule

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7; IC 27-1-12-10

Sec. 4.1. For any policy of insurance on the life of either a male or female insured on a form of insurance with separate rates for smokers and nonsmokers delivered or issued for delivery in this state after the operative date of IC 27-1-12-7(dd)(11) for that policy form, in addition to the mortality tables that may be used according to 760 IAC 1-32-4,

(i) a mortality table which is a blend of the male and female rates of mortality according to the 1980 CSO Smoker Mortality Table, in the case of lives classified as smokers, or the 1980 CSO Nonsmoker Mortality Table, in the case of lives classified as nonsmokers, with or without Ten-Year Select Mortality Factors, may at the option of the company be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors, and

(ii) a mortality table which is of the same blend as used in (i) but applied to form a blend of the male and female rates of mortality according to the corresponding 1980 CET Smoker Mortality Table or 1980 CET Nonsmoker Mortality Table may at the option of the company be substituted for the 1980 CET Table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. For any policy using one of the acceptable tables, the same acceptable table may be used in determining the minimum standard of valuation for that policy.

The following blended mortality tables will be considered acceptable:

SA: 100% Male 0% Female smoker tables designated as "1980 CSO-SA" and "1980 CET-SA" Tables.

SB: 80% Male 20% Female smoker tables designated as "1980 CSO-SA *[sic., CSO-SB]*" and "1980 CET-SB" Tables.

SC: 60% Male 40% Female smoker tables designated as "1980 CSO-SC" and "1980 CET-SC" Tables.

SD: 50% Male 50% Female smoker tables designated as "1980 CSO-SD" and "1980 CET-SD" Tables.

SE: 40% Male 60% Female smoker tables designated as "1980 CSO-SE" and "1980 CET-SE" Tables.

SF: 20% Male 80% Female smoker tables designated as "1980 CSO-SF" and "1980 CET-SF" Tables.
SG: 0% Male 100% Female smoker tables designated as "1980 CSO-SG" and "1980 CET-SG" Tables.
NA: 100% Male 0% Female nonsmoker tables designated as "1980 CSO-NA" and "1980 CET-NA" Tables.
NB: 80% Male 20% Female nonsmoker tables designated as "1980 CSO-NB" and "1980 CET-NB" Tables.
NC: 60% Male 40% Female nonsmoker tables designated as "1980 CSO-NC" and "1980 CET-NC" Tables.
ND: 50% Male 50% Female nonsmoker tables designated as "1980 CSO-ND" and "1980 CET-ND" Tables.
NE: 40% Male 60% Female nonsmoker tables designated as "1980 CSO-NE" and "1980 CET-NE" Tables.
NF: 20% Male 80% Female nonsmoker tables designated as "1980 CSO-NF" and "1980 CET-NF" Tables.
NG: 0% Male 100% Female nonsmoker tables designated as "1980 CSO-NG" and "1980 CET-NG" Tables.

Tables SA, SG, NA and NG are not acceptable as blended tables unless the proportion of persons insured is anticipated to be 90% or more of one sex or the other. *(Department of Insurance; 760 IAC 1-32-4.1; filed Jul 16, 1987, 3:20 pm: 10 IR 2704; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-32-5 Sex distinct and sex neutral bases for same kind of policy

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7; IC 27-4-1-4

Sec. 5. It shall not be in violation of IC 27-4-1-4(7)(a) for an insurer to issue the same kind of policy of life insurance on both sex distinct and sex neutral bases. *(Department of Insurance; 760 IAC 1-32-5; filed Jun 28, 1984, 12:46 pm: 7 IR 1929, eff Aug 1, 1984; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-32-6 Separability

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7

Sec. 6. If any provision of this rule *[760 IAC 1-32]* or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby. *(Department of Insurance; 760 IAC 1-32-6; filed Jun 28, 1984, 12:46 pm: 7 IR 1930, eff Aug 1, 1984; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-32-7 Effective date

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7

Sec. 7. The effective date of this rule *[760 IAC 1-32]* is August 1, 1984. *(Department of Insurance; 760 IAC 1-32-7; filed Jun 28, 1984, 12:46 pm: 7 IR 1930, eff Aug 1, 1984; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-32-8 Appendix I; Tables B, C, D, E and F

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7

Sec. 8.

TABLE B
BLENDED 1980 CSO & 1980 CET MORTALITY TABLES
PIVOTAL AGE IS 45 *** RATIO OF MALE LX TO TOTAL LX IS 80%

BLENDED 1980 CSO TABLE						BLENDED 1980 CET TABLE					
AGE	LX	1000QX	AGE	LX	1000QX	AGE	LX	1000QX	AGE	LX	1000QX
0	136260	3.92	50	122860	6.36	0	2437508	5.10	50	2104361	8.27
1	135726	1.04	51	122079	6.90	1	2425077	1.79	51	2086958	8.97

2	135585	.95	52	121237	7.50	2	2420736	1.70	52	2068238	9.75
3	135456	.94	53	120328	8.19	3	2416621	1.69	53	2048073	10.65
4	135329	.91	54	119343	8.96	4	2412537	1.66	54	2026261	11.65
5	135206	.87	55	118274	9.78	5	2408532	1.62	55	2002655	12.71
6	135088	.83	56	117117	10.67	6	2404630	1.58	56	1977201	13.87
7	134976	.79	57	115867	11.58	7	2400831	1.54	57	1949777	15.05
8	134869	.75	58	114525	12.54	8	2397134	1.50	58	1920433	16.30
9	134768	.73	59	113089	13.57	9	2393538	1.48	59	1889130	17.64
10	134670	.72	60	111554	14.72	10	2389996	1.47	60	1855806	19.14
11	134573	.75	61	109912	16.00	11	2386483	1.50	61	1820286	20.80
12	134472	.83	62	108153	17.47	12	2382903	1.58	62	1782424	22.71
13	134360	.94	63	106264	19.16	13	2379138	1.69	63	1741945	24.91
14	134234	1.08	64	104228	21.05	14	2375117	1.83	64	1698553	27.37
15	134089	1.24	65	102034	23.11	15	2370771	1.99	65	1652064	30.04
16	133923	1.39	66	99676	25.29	16	2366053	2.14	66	1602436	32.88
17	133737	1.53	67	97155	27.61	17	2360990	2.28	67	1549748	35.89
18	133532	1.62	68	94473	30.03	18	2355607	2.37	68	1494128	39.04
19	133316	1.69	69	91636	32.66	19	2350024	2.44	69	1435797	42.46
20	133091	1.74	70	88643	35.59	20	2344290	2.49	70	1374833	46.27
21	132859	1.75	71	85488	38.95	21	2338453	2.50	71	1311219	50.64
22	132626	1.73	72	82158	42.84	22	2332607	2.48	72	1244819	55.69
23	132397	1.71	73	78638	47.33	23	2326822	2.46	73	1175495	61.53
24	132171	1.69	74	74916	52.37	24	2321098	2.44	74	1103167	68.08
25	131948	1.65	75	70993	57.84	25	2315435	2.40	75	1028063	75.19
26	131730	1.63	76	66897	63.65	26	2309878	2.38	76	950763	82.75
27	131515	1.61	77	62630	69.70	27	2304380	2.36	77	872087	90.61
28	131303	1.61	78	58265	75.95	28	2298942	2.36	78	793067	98.74
29	131092	1.63	79	53840	82.57	29	2293516	2.38	79	714760	107.34
30	130878	1.65	80	49394	89.83	30	2288057	2.40	80	638038	116.78
31	130662	1.70	81	44957	97.94	31	2282566	2.45	81	563528	127.32
32	130440	1.75	82	40554	107.18	32	2276974	2.50	82	491780	139.33
33	130212	1.83	83	36207	117.65	33	2271282	2.58	83	423260	152.95
34	129974	1.91	84	31947	129.10	34	2265422	2.66	84	358522	167.83
35	129726	2.02	85	27823	141.38	35	2259396	2.77	85	298351	183.79
36	129464	2.14	86	23889	154.17	36	2253137	2.89	86	243517	200.42
37	129187	2.30	87	20206	167.49	37	2246625	3.05	87	194711	217.74
38	128890	2.47	88	16822	181.24	38	2239773	3.22	88	152315	235.61
39	128572	2.68	89	13773	195.54	39	2232561	3.48	89	116428	254.20
40	128227	2.90	90	11080	210.53	40	2224792	3.77	90	86832	273.69
41	127855	3.16	91	8747	226.51	41	2216405	4.11	91	63067	294.46
42	127451	3.42	92	6766	244.13	42	2207296	4.45	92	44496	317.37
43	127015	3.72	93	5114	264.04	43	2197474	4.84	93	30374	343.25
44	126543	4.01	94	3764	289.36	44	2106838	5.21	94	19948	376.17
45	126036	4.35	95	2675	324.89	45	2175445	5.66	95	12444	422.36

46	125488	4.70	96	1806	380.97	46	2163132	6.11	96	7188	495.26
47	124898	5.07	97	1118	477.69	47	2149915	6.59	97	3628	621.00
48	124265	5.45	98	584	657.38	48	2135747	7.09	98	1375	854.59
49	123588	5.89	99	200	1000.00	49	2120605	7.66	99	200	1000.00

TABLE C

BLENDED 1980 CSO & 1980 CET MORTALITY TABLES

PIVOTAL AGE IS 45 *** RATIO OF MALE LX TO TOTAL LX IS 60%

BLENDED 1980 CSO TABLE						BLENDED 1980 CET TABLE					
AGE	LX	1000QX	AGE	LX	1000QX	AGE	LX	1000QX	AGE	LX	1000QX
0	107405	3.67	50	97377	6.01	0	1760557	4.77	50	1529496	7.81
1	107011	.99	51	96792	6.50	1	1752159	1.74	51	1517551	8.45
2	106905	.93	52	96163	7.05	2	1749110	1.68	52	1504728	9.17
3	106806	.90	53	95485	7.68	3	1746171	1.65	53	1490930	9.98
4	106710	.88	54	94752	8.37	4	1743290	1.63	54	1476051	10.88
5	106616	.84	55	93959	9.11	5	1740448	1.59	55	1459992	11.84
6	106526	.81	56	93103	9.88	6	1737681	1.56	56	1442706	12.84
7	106440	.77	57	92183	10.68	7	1734970	1.52	57	1424182	13.88
8	106358	.73	58	91198	11.50	8	1732333	1.48	58	1404414	14.95
9	106280	.73	59	90149	12.39	9	1729769	1.48	59	1383418	16.11
10	106202	.71	60	89032	13.37	10	1727209	1.46	60	1361131	17.38
11	106127	.74	61	87842	14.48	11	1724687	1.49	61	1337475	18.82
12	106048	.80	62	86570	15.79	12	1722117	1.55	62	1312304	20.53
13	105963	.89	63	85203	17.30	13	1719448	1.64	63	1285362	22.49
14	105869	1.01	64	83729	19.01	14	1716628	1.76	64	1256454	24.71
15	105762	1.14	65	82137	20.88	15	1713607	1.89	65	1225407	27.14
16	105641	1.27	66	80422	22.84	16	1710368	2.02	66	1192149	29.69
17	105507	1.38	67	78585	24.90	17	1706913	2.13	67	1156754	32.37
18	105361	1.47	68	76628	27.04	18	1703277	2.22	68	1119310	35.15
19	105206	1.52	69	74556	29.32	19	1699496	2.27	69	1079966	38.12
20	105046	1.56	70	72370	31.92	20	1695638	2.31	70	1038798	41.50
21	104882	1.58	71	70060	34.90	21	1691721	2.33	71	995688	45.37
22	104716	1.58	72	67615	38.38	22	1687779	2.33	72	950514	49.89
23	104551	1.56	73	65020	42.48	23	1683846	2.31	73	903093	55.22
24	104388	1.55	74	62258	47.11	24	1679956	2.30	74	853224	61.24
25	104226	1.53	75	59325	52.16	25	1676092	2.28	75	800973	67.81
26	104067	1.52	76	56231	57.58	26	1672271	2.27	76	746659	74.85
27	103909	1.51	77	52993	63.24	27	1668475	2.26	77	690772	82.21
28	103752	1.53	78	49642	69.13	28	1664704	2.28	78	633984	89.87
29	103593	1.54	79	46210	75.41	29	1660908	2.29	79	577008	98.03
30	103433	1.58	80	42725	82.34	30	1657105	2.33	80	520444	107.04
31	103270	1.63	81	39207	90.17	31	1653244	2.38	81	464736	117.22
32	103102	1.67	82	35672	99.12	32	1649309	2.42	82	410260	128.86
33	102930	1.75	83	32136	109.33	33	1645318	2.50	83	357394	142.13
34	102750	1.83	84	28623	120.58	34	1641205	2.58	84	306598	156.75

35	102562	1.93	85	25172	132.68	35	1636971	2.68	85	258539	172.48
36	102364	2.04	86	21832	145.47	36	1632584	2.79	86	213946	189.11
37	102155	2.20	87	18656	158.84	37	1628029	2.95	87	173487	206.49
38	101930	2.36	88	15693	172.87	38	1623226	3.11	88	137664	224.73
39	101689	2.56	89	12980	187.54	39	1618178	3.33	89	106727	243.80
40	101429	2.78	90	10546	203.08	40	1612789	3.61	90	80707	264.00
41	101147	3.03	91	8404	219.76	41	1606967	3.94	91	59400	285.69
42	100841	3.29	92	6557	238.20	42	1600636	4.28	92	42430	309.66
43	100509	3.56	93	4995	259.26	43	1593785	4.63	93	29291	337.04
44	100151	3.84	94	3700	285.17	44	1586406	4.99	94	19419	370.72
45	99766	4.15	95	2645	322.03	45	1578490	5.40	95	12220	418.64
46	99352	4.47	96	1793	378.56	46	1569966	5.81	96	7104	492.13
47	98908	4.81	97	1114	476.70	47	1560844	6.25	97	3608	619.71
48	98432	5.17	98	583	657.10	48	1551089	6.72	98	1372	854.23
49	97923	5.58	99	200	1000.00	49	1540666	7.25	99	200	1000.00

TABLE D

BLENDED 1980 CSO & 1980 CET MORTALITY TABLES

PIVOTAL AGE IS 45 *** RATIO OF MALE LX TO TOTAL LX IS 50%

BLENDED 1980 CSO TABLE						BLENDED 1980 CET TABLE					
AGE	LX	1000QX	AGE	LX	1000QX	AGE	LX	1000QX	AGE	LX	1000QX
0	96981	3.54	50	88170	5.83	0	1528592	4.60	50	1332106	7.58
1	96638	.97	51	87656	6.30	1	1521560	1.72	51	1322009	8.19
2	96544	.91	52	87104	6.82	2	1518943	1.66	52	1311182	8.87
3	96456	.89	53	86510	7.42	3	1516422	1.64	53	1299552	9.65
4	96370	.85	54	85868	8.07	4	1513935	1.60	54	1287011	10.49
5	96288	.83	55	85175	8.77	5	1511513	1.58	55	1273510	11.40
6	96208	.79	56	84428	9.50	6	1509125	1.54	56	1258992	12.35
7	96132	.77	57	83626	10.23	7	1506801	1.52	57	1243443	13.30
8	96058	.73	58	82771	10.99	8	1504511	1.48	58	1226905	14.29
9	95988	.72	59	81861	11.81	9	1502284	1.47	59	1209373	15.35
10	95919	.71	60	80894	12.71	10	1500076	1.46	60	1190809	16.52
11	95851	.72	61	79866	13.75	11	1497886	1.47	61	1171137	17.88
12	95782	.78	62	78768	14.96	12	1495684	1.53	62	1150197	19.45
13	95707	.87	63	77590	16.39	13	1493396	1.62	63	1127826	21.31
14	95624	.97	64	76318	18.02	14	1490977	1.72	64	1103792	23.43
15	95531	1.10	65	74943	19.78	15	1488413	1.85	65	1077930	25.71
16	95426	1.21	66	73461	21.64	16	1485659	1.96	66	1050216	28.13
17	95311	1.31	67	71871	23.59	17	1482747	2.06	67	1020673	30.67
18	95186	1.39	68	70176	25.58	18	1479693	2.14	68	989369	33.25
19	95054	1.44	69	68381	27.73	19	1476526	2.19	69	956472	36.05
20	94917	1.48	70	66485	30.16	20	1473292	2.23	70	921991	39.21
21	94777	1.49	71	64480	32.96	21	1470007	2.24	71	885840	42.85
22	94636	1.50	72	62355	36.29	22	1466714	2.25	72	847882	47.18
23	94494	1.49	73	60092	40.20	23	1463414	2.24	73	807879	52.26

24	94353	1.49	74	57676	44.66	24	1460136	2.24	74	765659	58.06
25	94212	1.47	75	55100	49.55	25	1456865	2.22	75	721205	64.42
26	94074	1.47	76	52370	54.80	26	1453631	2.22	76	674745	71.24
27	93936	1.46	77	49500	60.31	27	1450404	2.21	77	626676	78.40
28	93799	1.48	78	46515	66.06	28	1447199	2.23	78	577545	85.88
29	93660	1.51	79	43442	72.23	29	1443972	2.26	79	527945	93.90
30	93519	1.54	80	40304	79.07	30	1440709	2.29	80	478371	102.79
31	93375	1.58	81	37117	86.80	31	1437410	2.33	81	429199	112.84
32	93227	1.64	82	33895	95.68	32	1434061	2.39	82	380768	124.38
33	93074	1.70	83	30652	105.81	33	1430634	2.45	83	333408	137.55
34	92916	1.79	84	27409	117.02	34	1427129	2.54	84	287548	152.13
35	92750	1.88	85	24202	129.11	35	1423504	2.63	85	243803	167.84
36	92576	2.00	86	21077	141.91	36	1419760	2.75	86	202883	184.48
37	92391	2.14	87	18086	155.41	37	1415856	2.89	87	165455	202.03
38	92193	2.31	88	15275	169.55	38	1411764	3.06	88	132028	220.42
39	91980	2.51	89	12685	184.45	39	1407444	3.26	89	102926	239.79
40	91749	2.72	90	10345	200.23	40	1402856	3.54	90	78245	260.30
41	91499	2.97	91	8274	217.23	41	1397890	3.86	91	57878	282.40
42	91227	3.22	92	6477	235.91	42	1392494	4.19	92	41533	306.68
43	90933	3.49	93	4949	257.43	43	1386659	4.54	93	28796	334.66
44	90616	3.75	94	3675	283.81	44	1380364	4.88	94	19159	368.95
45	90276	4.06	95	2632	320.74	45	1373628	5.28	95	12090	416.96
46	89909	4.36	96	1788	377.93	46	1366375	5.67	96	7049	491.31
47	89517	4.68	97	1112	476.61	47	1358628	6.08	97	3586	619.59
48	89092	5.03	98	582	656.44	48	1350368	6.54	98	1364	853.37
49	88650	5.41	99	200	1000.00	49	1341537	7.03	99	200	1000.00

TABLE E

BLENDED 1980 CSO & 1980 CET MORTALITY TABLES

PIVOTAL AGE IS 45 *** RATIO OF MALE LX TO TOTAL LX IS 40%

BLENDED 1980 CSO TABLE						BLENDED 1980 CET TABLE					
AGE	LX	1000QX	AGE	LX	1000QX	AGE	LX	1000QX	AGE	LX	1000QX
0	88415	3.41	50	80614	5.66	0	1345746	4.43	50	1176481	7.36
1	88114	.95	51	80158	6.10	1	1339784	1.70	51	1167822	7.93
2	88030	.89	52	79669	6.60	2	1337506	1.64	52	1158561	8.58
3	87952	.86	53	79143	7.16	3	1335312	1.61	53	1148621	9.31
4	87876	.84	54	78576	7.77	4	1333162	1.59	54	1137927	10.10
5	87802	.81	55	77965	8.43	5	1331042	1.56	55	1126434	10.96
6	87731	.78	56	77308	9.11	6	1328966	1.53	56	1114088	11.84
7	87663	.76	57	76604	9.79	7	1326933	1.51	57	1100897	12.73
8	87596	.72	58	75854	10.48	8	1324929	1.47	58	1086883	13.62
9	87533	.71	59	75059	11.23	9	1322981	1.46	59	1072080	14.60
10	87471	.70	60	74216	12.05	10	1321049	1.45	60	1056428	15.67
11	87410	.71	61	73322	13.01	11	1319133	1.46	61	1039874	16.91
12	87348	.77	62	72368	14.14	12	1317207	1.52	62	1022290	18.38

13	87281	.84	63	71345	15.50	13	1315205	1.59	63	1003500	20.15
14	87208	.94	64	70239	17.03	14	1313114	1.69	64	983279	22.14
15	87126	1.05	65	69043	18.71	15	1310895	1.80	65	961509	24.32
16	87035	1.15	66	67751	20.46	16	1308535	1.90	66	938125	26.60
17	86935	1.24	67	66365	22.31	17	1306049	1.99	67	913171	29.00
18	86827	1.31	68	64884	24.17	18	1303450	2.06	68	886689	31.42
19	86713	1.36	69	63316	26.18	19	1300765	2.11	69	858829	34.03
20	86595	1.39	70	61658	28.45	20	1298020	2.14	70	829603	36.99
21	86475	1.41	71	59904	31.10	21	1295242	2.16	71	798916	40.43
22	86353	1.42	72	58041	34.27	22	1292444	2.17	72	766616	44.55
23	86230	1.42	73	56052	38.02	23	1289639	2.17	73	732463	49.43
24	86108	1.42	74	53921	42.32	24	1286840	2.17	74	696257	55.02
25	85986	1.40	75	51639	47.05	25	1284048	2.15	75	657949	61.17
26	85866	1.41	76	49209	52.18	26	1281287	2.16	76	617702	67.83
27	85745	1.42	77	46641	57.57	27	1278519	2.17	77	575803	74.84
28	85623	1.44	78	43956	63.21	28	1275745	2.19	78	532710	82.17
29	85500	1.46	79	41178	69.29	29	1272951	2.21	79	488937	90.08
30	85375	1.50	80	38325	76.04	30	1270138	2.25	80	444894	98.85
31	85247	1.55	81	35411	83.72	31	1267280	2.30	81	400916	108.84
32	85115	1.60	82	32446	92.52	32	1264365	2.35	82	357280	120.28
33	84979	1.66	83	29444	102.65	33	1261394	2.41	83	314306	133.45
34	84838	1.75	84	26422	113.82	34	1258354	2.50	84	272362	147.97
35	84690	1.83	85	23415	125.93	35	1255208	2.58	85	232061	163.71
36	84535	1.95	86	20466	138.78	36	1251970	2.70	86	194070	180.41
37	84370	2.09	87	17626	152.39	37	1248590	2.84	87	159058	198.11
38	84194	2.25	88	14940	166.68	38	1245044	3.00	88	127547	216.68
39	84005	2.45	89	12450	181.76	39	1241309	3.20	89	99910	236.29
40	83799	2.66	90	10187	197.78	40	1237337	3.46	90	76302	257.11
41	83576	2.90	91	8172	215.12	41	1233056	3.77	91	56684	279.66
42	83334	3.15	92	6414	234.03	42	1228407	4.10	92	40832	304.24
43	83071	3.41	93	4913	255.85	43	1223371	4.43	93	28409	332.61
44	82788	3.66	94	3656	282.58	44	1217951	4.76	94	18960	367.35
45	82485	3.96	95	2623	319.76	45	1212154	5.15	95	11995	415.69
46	82158	4.24	96	1784	377.41	46	1205911	5.51	96	7009	490.63
47	81810	4.55	97	1111	476.21	47	1199266	5.92	97	3570	619.07
48	81438	4.89	98	582	656.10	48	1192166	6.36	98	1360	852.93
49	81040	5.26	99	200	1000.00	49	1184584	6.84	99	200	1000.00

TABLE F

BLENDED 1980 CSO & 1980 CET MORTALITY TABLES

PIVOTAL AGE IS 45 *** RATIO OF MALE LX TO TOTAL LX IS 20%

	BLENDED 1980 CSO TABLE						BLENDED 1980 CET TABLE				
AGE	LX	1000QX	AGE	LX	1000QX	AGE	LX	1000QX	AGE	LX	1000QX
0	75108	3.15	50	68862	5.31	0	1080889	4.10	50	950863	6.90
1	74871	.92	51	68496	5.70	1	1076457	1.67	51	944302	7.41

2	74802	.85	52	68106	6.15	2	1074659	1.60	52	937305	8.00
3	74738	.82	53	67687	6.65	3	1072940	1.57	53	929807	8.65
4	74677	.81	54	67237	7.19	4	1071255	1.56	54	921764	9.35
5	74617	.79	55	66754	7.76	5	1069584	1.54	55	913146	10.09
6	74558	.76	56	66236	8.34	6	1067937	1.51	56	903932	10.84
7	74501	.74	57	65684	8.91	7	1066324	1.49	57	894133	11.58
8	74446	.71	58	65099	9.47	8	1064735	1.46	58	883779	12.31
9	74393	.70	59	64483	10.08	9	1063180	1.45	59	872900	13.10
10	74341	.70	60	63833	10.75	10	1061638	1.45	60	861465	13.98
11	74289	.70	61	63147	11.55	11	1060099	1.45	61	849422	15.02
12	74237	.74	62	62418	12.54	12	1058562	1.49	62	836664	16.30
13	74182	.80	63	61635	13.74	13	1056985	1.55	63	823026	17.86
14	74123	.86	64	60788	15.10	14	1055347	1.61	64	808327	19.63
15	74059	.95	65	59870	16.62	15	1053648	1.70	65	792460	21.61
16	73989	1.03	66	58875	18.19	16	1051857	1.78	66	775335	23.65
17	73913	1.09	67	57804	19.81	17	1049985	1.84	67	756998	25.75
18	73832	1.15	68	56659	21.45	18	1048053	1.90	68	737505	27.89
19	73747	1.19	69	55444	23.19	19	1046062	1.94	69	716936	30.15
20	73659	1.22	70	54158	25.19	20	1044033	1.97	70	695320	32.75
21	73569	1.24	71	52794	27.57	21	1041976	1.99	71	672548	35.84
22	73478	1.25	72	51338	30.43	22	1039902	2.00	72	648444	39.56
23	73386	1.27	73	49776	33.92	23	1037822	2.02	73	622792	44.10
24	73293	1.28	74	48088	37.94	24	1035726	2.03	74	595327	49.32
25	73199	1.29	75	46264	42.43	25	1033623	2.04	75	565965	55.16
26	73105	1.30	76	44301	47.33	26	1031514	2.05	76	534746	61.53
27	73010	1.31	77	42204	52.53	27	1029399	2.06	77	501843	68.29
28	72914	1.35	78	39987	58.03	28	1027278	2.10	78	467572	75.44
29	72816	1.38	79	37667	63.98	29	1025121	2.13	79	432298	83.17
30	72716	1.42	80	35257	70.65	30	1022937	2.17	80	396344	91.85
31	72613	1.47	81	32766	78.26	31	1020717	2.22	81	359940	101.74
32	72506	1.52	82	30202	87.04	32	1018451	2.27	82	323320	113.15
33	72396	1.58	83	27573	97.15	33	1016139	2.33	83	286736	126.30
34	72282	1.66	84	24894	108.33	34	1013771	2.41	84	250521	140.83
35	72162	1.74	85	22197	120.52	35	1011328	2.49	85	215240	156.68
36	72036	1.85	86	19522	133.53	36	1008810	2.60	86	181516	173.59
37	71903	1.99	87	16915	147.37	37	1006187	2.74	87	150007	191.58
38	71760	2.15	88	14422	161.93	38	1003430	2.90	88	121269	210.51
39	71606	2.32	89	12087	177.40	39	1000520	3.07	89	95741	230.62
40	71440	2.54	90	9943	193.80	40	997448	3.30	90	73661	251.94
41	71259	2.77	91	8016	211.61	41	994156	3.60	91	55103	275.09
42	71062	3.02	92	6320	231.05	42	990577	3.93	92	39945	300.37
43	70847	3.25	93	4860	253.44	43	986684	4.23	93	27947	329.47
44	70617	3.49	94	3628	280.66	44	982510	4.54	94	18739	364.86
45	70371	3.75	95	2610	318.37	45	978049	4.88	95	11902	413.88

46	70107	4.02	96	1779	376.21	46	973276	5.23	96	6976	489.07
47	69825	4.30	97	1110	475.72	47	968186	5.59	97	3564	618.44
48	69525	4.61	98	582	656.09	48	962774	5.99	98	1360	852.92
49	69204	4.94	99	200	1000.00	49	957007	6.42	99	200	1000.00

(Department of Insurance; 760 IAC 1-32-8; filed Jun 28, 1984, 12:46 pm: 7 IR 1930, eff Aug 1, 1984; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-32-9 Appendix II; select factors for blended 1980 CSO mortality tables; December 4, 1983

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7

Sec. 9. The select factors for use with the 1980 CSO tables are different for males and females but select factors for use with the blended 1980 CSO tables must themselves be blended.

The tables of ratios of male lx to total lx shown in the report of our committee indicate that for most of the insuring ages the ratios of males and females in the blended tables do not differ significantly from the ratio at the pivotal age. This suggests that the pivotal age ratio can be used for all ages.

The select factors must also be weighted for the relative male and female mortality rates. Considering the nature of the select factors and the need for a practicable solution, it seems reasonable to assume that female mortality is 60% of male mortality. Using the pivotal age ratios (=z) and assuming female mortality is 60% of male mortality the blended factors can be obtained from:

$$ {}^{Z}F_t^{T} = [Z/100 \times F_t^{M} + 0.6\ (1\text{-}Z/100)F_t^{F}] \div [Z/100 + 0.6\ (1\text{-}Z/100)] $$

Where Z is the ratio % at the pivotal age of lx male to lx total and F_t^{M} and F_t^{F} are the male and female selection factors for year t and ${}^{Z}F_t^{T}$ is the selection factor applicable to the blended CSO table having Z% male lx to total lx at the pivotal age. *(Department of Insurance; 760 IAC 1-32-9; filed Jun 28, 1984, 12:46 pm: 7 IR 1936, eff Aug 1, 1984; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-32-10 Appendix III; Tables SB, SC, SD, SE, SF, NB, NC, ND, NE, NF

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7; IC 27-1-12-10

Sec. 10.

1980 CSO-SB SMOKER TABLE & 1980 CET-SB SMOKER TABLE[#]

Pivotal Age is 45 *** Ratio of Male l_x to Total is 80%

1980 CSO-SB SMOKER TABLE						1980 CET-SB SMOKER TABLE					
Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$
15	223083	1.51	60	173641	20.93	15	4675331	2.26	60	3363577	27.21
16	222746	1.70	61	170007	22.72	16	4664765	2.45	61	3272054	29.54
17	222367	1.85	62	166144	24.75	17	4653336	2.60	62	3175398	32.18
18	221956	1.95	63	162032	27.09	18	4641237	2.70	63	3073214	35.22
19	221523	2.04	64	157643	29.66	19	4628706	2.79	64	2964975	38.56
20	221071	2.09	65	152967	32.45	20	4615792	2.84	65	2850646	42.19
21	220609	2.10	66	148003	35.33	21	4602683	2.85	66	2730377	45.93
22	220146	2.09	67	142774	38.33	22	4589565	2.84	67	2604971	49.83
23	219686	2.06	68	137301	41.34	23	4576531	2.81	68	2475165	53.74
24	219233	2.03	69	131625	44.56	24	4563671	2.78	69	2342150	57.93
25	218788	1.97	70	125760	48.06	25	4550984	2.72	70	2206469	62.48
26	218357	1.93	71	119716	52.02	26	4538605	2.68	71	2068609	67.63
27	217936	1.92	72	113488	56.56	27	4526442	2.67	72	1928709	73.53

28	217518	1.92	73	107069	61.72	28	4514356	2.67	73	1786891	80.24
29	217100	1.94	74	100461	67.39	29	4502303	2.69	74	1643511	87.61
30	216679	1.99	75	93691	73.64	30	4490192	2.74	75	1499523	95.73
31	216248	2.06	76	86792	80.11	31	4477889	2.81	76	1355974	104.14
32	215803	2.13	77	79839	86.64	32	4465306	2.88	77	1214763	112.63
33	215343	2.23	78	72922	93.17	33	4452446	2.98	78	1077944	121.12
34	214863	2.35	79	66128	99.91	34	4439178	3.10	79	947383	129.88
35	214358	2.50	80	59521	107.14	35	4425417	3.25	80	824337	139.28
36	213822	2.67	81	53144	115.11	36	4411034	3.47	81	709523	149.64
37	213251	2.89	82	47027	124.03	37	4395728	3.76	82	603350	161.24
38	212635	3.14	83	41194	134.01	38	4379200	4.08	83	506066	174.21
39	211967	3.43	84	35674	144.97	39	4361333	4.46	84	417904	188.46
40	211240	3.75	85	30502	156.08	40	4341881	4.88	85	339146	202.90
41	210448	4.14	86	25741	167.75	41	4320693	5.38	86	270333	218.08
42	209577	4.53	87	21423	179.03	42	4297448	5.89	87	211379	232.74
43	208628	4.97	88	17588	191.74	43	4272136	6.46	88	162183	249.26
44	207591	5.42	89	14216	204.04	44	4244538	7.05	89	121757	265.25
45	206466	5.94	90	11315	217.42	45	4214614	7.72	90	89461	282.65
46	205240	6.45	91	8855	231.58	46	4182077	8.39	91	64175	301.05
47	203916	7.01	92	6804	246.88	47	4146989	9.11	92	44855	320.94
48	202487	7.60	93	5124	265.45	48	4109210	9.88	93	30459	345.09
49	200948	8.25	94	3764	289.36	49	4068611	10.73	94	19948	376.17
50	199290	8.95	95	2675	324.89	50	4024955	11.64	95	12444	422.36
51	197506	9.74	96	1806	380.97	51	3978105	12.66	96	7188	495.26
52	195582	10.63	97	1118	477.69	52	3927742	13.82	97	3628	621.00
53	193503	11.64	98	584	657.38	53	3873461	15.13	98	1375	854.59
54	191251	12.77	99	200	1000.00	54	3814856	16.60	99	200	1000.00
55	188809	13.96				55	3751529	18.15			
56	186173	15.24				56	3683439	19.81			
57	183336	16.55				57	3610470	21.52			
58	180302	17.93				58	3532773	23.31			
59	177069	19.36				59	3450424	25.17			

[#]Age nearest birthday

1980 CSO-SC SMOKER TABLE & 1980 CET-SC SMOKER TABLE[#]

Pivotal Age is 45 *** Ratio of Male l_x to Total is 60%

1980 CSO-SC SMOKER TABLE						1980 CET-SC SMOKER TABLE					
Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$
15	161242	1.37	60	127934	18.74	15	3003428	2.12	60	2213228	24.36
16	161021	1.52	61	125537	20.27	16	2997061	2.27	61	2159314	26.35
17	160776	1.65	62	122992	22.02	17	2990258	2.40	62	2102416	28.63
18	160511	1.74	63	120284	24.08	18	2983081	2.49	63	2042224	31.30
19	160232	1.82	64	117388	26.36	19	2975653	2.57	64	1978302	34.27
20	159940	1.86	65	114294	28.83	20	2968006	2.61	65	1910506	37.48
21	159643	1.88	66	110999	31.35	21	2960260	2.63	66	1838900	40.76

22	159343	1.87	67	107519	33.97	22	2952475	2.62	67	1763946	44.16
23	159045	1.85	68	103867	36.55	23	2944740	2.60	68	1686050	47.52
24	158751	1.84	69	100071	39.31	24	2937084	2.59	69	1605929	51.10
25	158459	1.81	70	96137	42.29	25	2929477	2.56	70	1523866	54.98
26	158172	1.79	71	92071	45.73	26	2921978	2.54	71	1440084	59.45
27	157889	1.79	72	87861	49.75	27	2914556	2.54	72	1354471	64.68
28	157606	1.79	73	83490	54.37	28	2907153	2.54	73	1266864	70.68
29	157324	1.83	74	78951	59.53	29	2899769	2.58	74	1177322	77.39
30	157036	1.88	75	74251	65.21	30	2892288	2.63	75	1086209	84.77
31	156741	1.95	76	69409	71.12	31	2884681	2.70	76	994131	92.46
32	156435	2.02	77	64473	77.16	32	2876892	2.77	77	902214	100.31
33	156119	2.11	78	59498	83.23	33	2868923	2.86	78	811713	108.20
34	155790	2.23	79	54546	89.55	34	2860718	2.98	79	723886	116.42
35	155443	2.35	80	49661	96.42	35	2852193	3.10	80	639611	125.35
36	155078	2.52	81	44873	104.08	36	2843351	3.28	81	559436	135.30
37	154687	2.74	82	40203	112.72	37	2834025	3.56	82	483744	146.54
38	154263	2.98	83	35671	122.47	38	2823936	3.87	83	412856	159.21
39	153803	3.25	84	31302	133.48	39	2813007	4.23	84	347125	173.52
40	153303	3.56	85	27124	144.59	40	2801108	4.63	85	286892	187.97
41	152757	3.94	86	23202	156.67	41	2788139	5.12	86	232965	203.67
42	152155	4.31	87	19567	168.41	42	2773864	5.60	87	185517	218.93
43	151499	4.71	88	16272	181.66	43	2758330	6.12	88	144902	236.16
44	150785	5.14	89	13316	194.45	44	2741449	6.68	89	110682	252.79
45	150010	5.61	90	10727	208.76	45	2723136	7.29	90	82703	271.39
46	149168	6.08	91	8488	223.98	46	2703284	7.90	91	60258	291.17
47	148261	6.59	92	6587	240.65	47	2681928	8.57	92	42713	312.85
48	147284	7.12	93	5002	260.28	48	2658944	9.26	93	29350	338.36
49	146235	7.71	94	3700	285.17	49	2634322	10.02	94	19419	370.72
50	145108	8.35	95	2645	322.03	50	2607926	10.86	95	12220	418.64
51	143896	9.05	96	1793	378.56	51	2579604	11.77	96	7104	492.13
52	142594	9.84	97	1114	476.70	52	2549242	12.79	97	3608	619.71
53	141191	10.75	98	583	657.10	53	2516637	13.98	98	1372	854.23
54	139673	11.75	99	200	1000.00	54	2481454	15.28	99	200	1000.00
55	138032	12.80				55	2443537	16.64			
56	136265	13.92				56	2402877	18.10			
57	134368	15.05				57	2359385	19.57			
58	132346	16.21				58	2313212	21.07			
59	130201	17.41				59	2264473	22.63			

[#]Age nearest birthday

1980 CSO-SD SMOKER TABLE & 1980 CET-SD SMOKER TABLE[#]

Pivotal Age is 45 *** Ratio of Male l_x to Total is 50%

1980 CSO-SD SMOKER TABLE						1980 CET-SD SMOKER TABLE					
Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$
15	141303	1.30	60	113195	17.67	15	2503786	2.05	60	1867210	22.97

16	141119	1.44	61	111195	19.07	16	2498653	2.19	61	1824320	24.79
17	140916	1.55	62	109075	20.69	17	2493181	2.30	62	1779095	26.90
18	140698	1.63	63	106818	22.62	18	2487447	2.38	63	1731237	29.41
19	140469	1.71	64	104402	24.76	19	2481527	2.46	64	1680321	32.19
20	140229	1.74	65	101817	27.09	20	2475422	2.49	65	1626231	35.22
21	139985	1.76	66	99059	29.46	21	2469258	2.51	66	1568955	38.30
22	139739	1.76	67	96141	31.91	22	2463060	2.51	67	1508864	41.48
23	139493	1.75	68	93073	34.28	23	2456878	2.50	68	1446276	44.56
24	139249	1.74	69	89882	36.86	24	2450736	2.49	69	1381830	47.92
25	139007	1.72	70	86569	39.60	25	2444634	2.47	70	1315613	51.48
26	138768	1.71	71	83141	42.85	26	2438596	2.46	71	1247885	55.71
27	138531	1.72	72	79578	46.65	27	2432597	2.47	72	1178365	60.65
28	138293	1.73	73	75866	51.06	28	2426588	2.48	73	1106897	66.38
29	138054	1.77	74	71992	56.02	29	2420570	2.52	74	1033421	72.83
30	137810	1.82	75	67959	61.49	30	2414470	2.57	75	958157	79.94
31	137559	1.89	76	63780	67.22	31	2408265	2.64	76	881562	87.39
32	137299	1.96	77	59493	73.10	32	2401907	2.71	77	804522	95.03
33	137030	2.05	78	55144	79.03	33	2395398	2.80	78	728068	102.74
34	136749	2.17	79	50786	85.26	34	2388691	2.92	79	653266	110.84
35	136452	2.29	80	46456	92.04	35	2381716	3.04	80	580858	119.65
36	136140	2.45	81	42180	99.64	36	2374476	3.20	81	511358	129.53
37	135806	2.67	82	37977	108.24	37	2366878	3.47	82	445122	140.71
38	135443	2.90	83	33866	117.99	38	2358665	3.77	83	382489	153.39
39	135050	3.16	84	29870	129.09	39	2349773	4.11	84	323819	167.82
40	134623	3.47	85	26014	140.30	40	2340115	4.51	85	269476	182.39
41	134156	3.83	86	22364	152.63	41	2329561	4.98	86	220326	198.42
42	133642	4.20	87	18951	164.55	42	2317960	5.46	87	176609	213.92
43	133081	4.59	88	15833	178.09	43	2305304	5.97	88	138829	231.52
44	132470	4.99	89	13013	191.10	44	2291541	6.49	89	106687	248.43
45	131809	5.44	90	10526	205.79	45	2276669	7.07	90	80183	267.53
46	131092	5.89	91	8360	221.41	46	2260573	7.66	91	58732	287.83
47	130320	6.37	92	6509	238.61	47	2243257	8.28	92	41827	310.19
48	129490	6.88	93	4956	258.45	48	2224683	8.94	93	28853	335.99
49	128599	7.43	94	3675	283.81	49	2204794	9.66	94	19159	368.95
50	127644	8.04	95	2632	320.74	50	2183496	10.45	95	12090	416.96
51	126618	8.71	96	1788	377.93	51	2160678	11.32	96	7049	491.31
52	125515	9.46	97	1112	476.61	52	2136219	12.30	97	3586	619.59
53	124328	10.31	98	582	656.44	53	2109944	13.40	98	1364	853.37
54	123046	11.25	99	200	1000.00	54	2081671	14.63	99	200	1000.00
55	121662	12.23				55	2051216	15.90			
56	120174	13.26				56	2018602	17.24			
57	118580	14.30				57	1983801	18.59			
58	116884	15.36				58	1946922	19.97			
59	115089	16.46				59	1908042	21.40			

[#]Age nearest birthday

1980 CSO-SE SMOKER TABLE & 1980 CET-SE SMOKER TABLE[#]

Pivotal Age is 45 *** Ratio of Male l_x to Total is 40%

1980 CSO-SE SMOKER TABLE						1980 CET-SE SMOKER TABLE					
Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$
15	125734	1.22	60	101679	16.61	15	2133431	1.97	60	1609925	21.59
16	125581	1.35	61	99990	17.89	16	2129228	2.10	61	1575167	23.26
17	125411	1.45	62	98201	19.38	17	2124757	2.20	62	1538529	25.19
18	125229	1.52	63	96298	21.20	18	2120083	2.27	63	1499773	27.56
19	125039	1.59	64	94256	23.20	19	2115270	2.34	64	1458439	30.16
20	124840	1.63	65	92069	25.40	20	2110320	2.38	65	1414452	33.02
21	124637	1.65	66	89730	27.62	21	2105297	2.40	66	1367747	35.91
22	124431	1.65	67	87252	29.91	22	2100244	2.40	67	1318631	38.88
23	124226	1.65	68	84642	32.12	23	2095203	2.40	68	1267363	41.76
24	124021	1.65	69	81923	34.50	24	2090175	2.40	69	1214438	44.85
25	123816	1.64	70	79097	37.05	25	2085159	2.39	70	1159970	48.17
26	123613	1.64	71	76166	40.10	26	2080175	2.39	71	1104094	52.13
27	123410	1.66	72	73112	43.72	27	2075203	2.41	72	1046538	56.84
28	123205	1.67	73	69916	47.97	28	2070202	2.42	73	987053	62.36
29	122999	1.71	74	66562	52.76	29	2065192	2.46	74	925500	68.59
30	122789	1.77	75	63050	58.07	30	2060112	2.52	75	862020	75.49
31	122572	1.84	76	59389	63.65	31	2054921	2.59	76	796946	82.75
32	122346	1.91	77	55609	69.39	32	2049599	2.66	77	730999	90.21
33	122112	1.99	78	51750	75.26	33	2044147	2.74	78	665056	97.84
34	121869	2.11	79	47855	81.40	34	2038546	2.86	79	599987	105.82
35	121612	2.22	80	43960	88.17	35	2032716	2.97	80	536496	114.62
36	121342	2.38	81	40084	95.75	36	2026679	3.13	81	475003	124.48
37	121053	2.59	82	36246	104.35	37	2020335	3.37	82	415875	135.66
38	120739	2.82	83	32464	114.13	38	2013526	3.67	83	359457	148.37
39	120399	3.08	84	28759	125.35	39	2006136	4.00	84	306124	162.96
40	120028	3.38	85	25154	136.67	40	1998111	4.39	85	256238	177.67
41	119622	3.73	86	21716	149.23	41	1989339	4.85	86	210712	194.00
42	119176	4.09	87	18475	161.37	42	1979691	5.32	87	169834	209.78
43	118689	4.46	88	15494	175.15	43	1969159	5.80	88	134206	227.70
44	118160	4.85	89	12780	188.35	44	1957738	6.31	89	103647	244.86
45	117587	5.28	90	10373	203.38	45	1945385	6.86	90	78268	264.39
46	116966	5.70	91	8263	219.41	46	1932040	7.41	91	57575	285.23
47	116299	6.16	92	6450	236.87	47	1917724	8.01	92	41153	307.93
48	115583	6.64	93	4922	257.15	48	1902363	8.63	93	28481	334.30
49	114816	7.16	94	3656	282.58	49	1885946	9.31	94	18960	367.35
50	113994	7.74	95	2623	319.76	50	1868388	10.06	95	11995	415.69
51	113112	8.36	96	1784	377.41	51	1849592	10.87	96	7009	490.63
52	112166	9.07	97	1111	476.21	52	1829487	11.79	97	3570	619.07
53	111149	9.87	98	582	656.10	53	1807917	12.83	98	1360	852.93

54	110052	10.74	99	200	1000.00	54	1784721	13.96	99	200	1000.00
55	108870	11.65				55	1759806	15.15			
56	107602	12.61				56	1733145	16.39			
57	106245	13.57				57	1704739	17.64			
58	104803	14.52				58	1674667	18.88			
59	103281	15.51				59	1643049	20.16			

[#]Age nearest birthday

1980 CSO-SF SMOKER TABLE & 1980 CET-SF SMOKER TABLE[#]

Pivotal Age is 45 *** Ratio of Male l_x to Total is 20%

1980 CSO-SF SMOKER TABLE						1980 CET-SF SMOKER TABLE					
Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$
15	102794	1.08	60	84713	14.53	15	1629026	1.83	60	1258542	18.89
16	102683	1.17	61	83482	15.59	16	1626045	1.92	61	1234768	20.27
17	102563	1.25	62	82181	16.84	17	1622923	2.00	62	1209739	21.89
18	102435	1.31	63	80797	18.43	18	1619677	2.06	63	1183258	23.96
19	102301	1.36	64	79308	20.20	19	1616340	2.11	64	1154907	26.26
20	102162	1.39	65	77706	22.15	20	1612930	2.14	65	1124579	28.80
21	102020	1.42	66	75985	24.10	21	1609478	2.17	66	1092191	31.33
22	101875	1.43	67	74154	26.12	22	1605985	2.18	67	1057973	33.96
23	101729	1.44	68	72217	28.01	23	1602484	2.19	68	1022044	36.41
24	101583	1.46	69	70194	30.09	24	1598975	2.21	69	984831	39.12
25	101435	1.47	70	68082	32.29	25	1595441	2.22	70	946304	41.98
26	101286	1.49	71	65884	35.04	26	1591899	2.24	71	906578	45.55
27	101135	1.52	72	63575	38.36	27	1588333	2.27	72	865283	49.87
28	100981	1.54	73	61136	42.33	28	1584727	2.29	73	822131	55.03
29	100825	1.60	74	58548	46.89	29	1581098	2.35	74	776889	60.96
30	100664	1.66	75	55803	51.94	30	1577382	2.41	75	729530	67.52
31	100497	1.72	76	52905	57.33	31	1573581	2.47	76	680272	74.53
32	100324	1.80	77	49872	62.93	32	1569694	2.55	77	629571	81.81
33	100143	1.87	78	46734	68.70	33	1565691	2.62	78	578066	89.31
34	99956	1.98	79	43523	74.83	34	1561589	2.73	79	526439	97.28
35	99758	2.08	80	40266	81.61	35	1557326	2.83	80	475227	106.09
36	99551	2.23	81	36980	89.22	36	1552919	2.98	81	424810	115.99
37	99329	2.44	82	33681	97.92	37	1548291	3.19	82	375536	127.30
38	99087	2.65	83	30383	107.82	38	1543352	3.45	83	327730	140.17
39	98824	2.90	84	27107	119.31	39	1538027	3.77	84	281792	155.10
40	98537	3.19	85	23873	130.86	40	1532229	4.15	85	238086	170.12
41	98223	3.53	86	20749	143.85	41	1525870	4.59	86	197583	187.01
42	97876	3.86	87	17764	156.39	42	1518866	5.02	87	160633	203.31
43	97498	4.21	88	14986	170.57	43	1511241	5.47	88	127975	221.74
44	97088	4.56	89	12430	184.17	44	1502975	5.93	89	99598	239.42
45	96645	4.94	90	10141	199.71	45	1494062	6.42	90	75752	259.62
46	96168	5.33	91	8116	216.27	46	1484470	6.93	91	56085	281.15
47	95655	5.74	92	6361	234.41	47	1474183	7.46	92	40317	304.73

48	95106	6.16	93	4870	255.00	48	1463186	8.01	93	28031	331.50
49	94520	6.62	94	3628	280.66	49	1451466	8.61	94	18739	364.86
50	93894	7.14	95	2610	318.37	50	1438969	9.28	95	11902	413.88
51	93224	7.68	96	1779	376.21	51	1425615	9.98	96	6976	489.07
52	92508	8.29	97	1110	475.72	52	1411387	10.78	97	3564	618.44
53	91741	9.00	98	582	656.09	53	1396172	11.70	98	1360	852.92
54	90915	9.74	99	200	1000.00	54	1379837	12.66	99	200	1000.00
55	90029	10.52				55	1362368	13.68			
56	89082	11.33				56	1343731	14.73			
57	88073	12.11				57	1323938	15.74			
58	87006	12.87				58	1303099	16.73			
59	85886	13.66				59	1281298	17.76			

[#]Age nearest birthday

1980 CSO-NB NON-SMOKER TABLE & 1980 CET-NB NON-SMOKER TABLE[#]

Pivotal Age is 45 *** Ratio of Male l_x to Total is 80%

1980 CSO-NB NON-SMOKER TABLE						1980 CET-NB NON-SMOKER TABLE					
Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$
15	116700	1.20	60	100990	11.80	15	1977580	1.95	60	1626420	15.34
16	116560	1.32	61	99798	12.96	16	1973724	2.07	61	1601471	16.85
17	116406	1.42	62	98505	14.30	17	1969638	2.17	62	1574486	18.59
18	116241	1.47	63	97096	15.86	18	1965364	2.22	63	1545216	20.62
19	116070	1.52	64	95556	17.62	19	1961001	2.27	64	1513354	22.91
20	115894	1.55	65	93872	19.55	20	1956550	2.30	65	1478683	25.42
21	115714	1.55	66	92037	21.64	21	1952050	2.30	66	1441095	28.13
22	115535	1.52	67	90045	23.87	22	1947560	2.27	67	1400557	31.03
23	115359	1.50	68	87896	26.24	23	1943139	2.25	68	1357098	34.11
24	115186	1.47	69	85590	28.82	24	1938767	2.22	69	1310807	37.47
25	115017	1.44	70	83123	31.74	25	1934463	2.19	70	1261691	41.26
26	114851	1.41	71	80485	35.51	26	1930227	2.16	71	1209634	46.16
27	114689	1.40	72	77627	38.89	27	1926058	2.15	72	1153797	50.56
28	114528	1.38	73	74608	43.37	28	1921917	2.13	73	1095461	56.38
29	114370	1.40	74	71372	48.39	29	1917823	2.15	74	1033699	62.91
30	114210	1.40	75	67918	53.84	30	1913700	2.15	75	968669	69.99
31	114050	1.43	76	64261	59.65	31	1909586	2.18	76	900872	77.55
32	113887	1.46	77	60428	65.77	32	1905423	2.21	77	831009	85.50
33	113721	1.50	78	56454	72.13	33	1901212	2.25	78	759958	93.77
34	113550	1.58	79	52382	78.92	34	1896934	2.33	79	688697	102.60
35	113371	1.64	80	48248	86.40	35	1892514	2.39	80	618037	112.32
36	113185	1.73	81	44079	94.77	36	1887991	2.48	81	548619	123.20
37	112989	1.83	82	39902	104.26	37	1883309	2.58	82	481029	135.54
38	112782	1.96	83	35742	115.02	38	1878450	2.71	83	415830	149.53
39	112561	2.10	84	31631	126.80	39	1873359	2.85	84	353651	164.84
40	112325	2.25	85	27620	139.45	40	1868020	3.00	85	295355	181.29
41	112072	2.43	86	23768	152.61	41	1862416	3.18	86	241810	198.39

42	111800	2.60	87	20141	166.38	42	1856494	3.38	87	193837	216.29
43	111509	2.81	88	16790	180.45	43	1850219	3.65	88	151912	234.59
44	111196	3.01	89	13760	195.03	44	1843466	3.91	89	116275	253.54
45	110861	3.26	90	11076	210.29	45	1836258	4.24	90	86795	273.38
46	110500	3.51	91	8747	226.51	46	1828472	4.56	91	63067	294.46
47	110112	3.78	92	6766	244.13	47	1820134	4.91	92	44496	317.37
48	109696	4.09	93	5114	264.04	48	1811197	5.32	93	30374	343.25
49	109247	4.41	94	3764	289.36	49	1801561	5.73	94	19948	376.17
50	108765	4.76	95	2675	324.89	50	1791238	6.19	95	12444	422.36
51	108247	5.18	96	1806	380.97	51	1780150	6.73	96	7188	495.26
52	107686	5.65	97	1118	477.69	52	1768170	7.35	97	3628	621.00
53	107078	6.19	98	584	657.38	53	1755174	8.05	98	1375	854.59
54	106415	6.81	99	200	1000.00	54	1741045	8.85	99	200	1000.00
55	105690	7.48				55	1725637	9.72			
56	104899	8.21				56	1708864	10.67			
57	104038	9.00				57	1690630	11.70			
58	103102	9.84				58	1670850	12.79			
59	102087	10.75				59	1649480	13.98			

[#]Age nearest birthday

1980 CSO-NC NON-SMOKER TABLE & 1980 CET-NC NON-SMOKER TABLE[#]

Pivotal Age is 45 *** Ratio of Male l_x to Total is 60%

1980 CSO-NC NON-SMOKER TABLE						1980 CET-NC NON-SMOKER TABLE					
Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$
15	95229	1.11	60	82926	10.97	15	1495453	1.86	60	1239148	14.26
16	95123	1.22	61	82016	12.01	16	1492671	1.97	61	1221478	15.61
17	95007	1.29	62	81031	13.21	17	1489730	2.04	62	1202411	17.17
18	94884	1.34	63	79961	14.62	18	1486691	2.09	63	1181766	19.01
19	94757	1.39	64	78792	16.24	19	1483584	2.14	64	1159301	21.11
20	94625	1.41	65	77512	18.01	20	1480409	2.16	65	1134828	23.41
21	94492	1.42	66	76116	19.91	21	1477211	2.17	66	1108262	25.88
22	94358	1.40	67	74601	21.94	22	1474005	2.15	67	1079580	28.52
23	94226	1.39	68	72964	24.05	23	1470836	2.14	68	1048790	31.27
24	94095	1.37	69	71209	26.35	24	1467688	2.12	69	1015994	34.26
25	93966	1.35	70	69333	28.95	25	1464577	2.10	70	981186	37.64
26	93839	1.33	71	67326	32.26	26	1461501	2.08	71	944254	41.94
27	93714	1.33	72	65154	35.42	27	1458461	2.08	72	904652	46.05
28	93589	1.33	73	62846	39.52	28	1455427	2.08	73	862993	51.38
29	93465	1.35	74	60362	44.17	29	1452400	2.10	74	818652	57.42
30	93339	1.36	75	57696	49.24	30	1449350	2.11	75	771645	64.01
31	93212	1.39	76	54855	54.70	31	1446292	2.14	76	722252	71.11
32	93082	1.42	77	51854	60.43	32	1443197	2.17	77	670893	78.56
33	92950	1.47	78	48720	66.46	33	1440065	2.22	78	618188	86.40
34	92813	1.53	79	45482	72.92	34	1436868	2.28	79	564777	94.80
35	92671	1.60	80	42165	80.06	35	1433592	2.35	80	511236	104.08

36	92523	1.68	81	38789	88.10	36	1430223	2.43	81	458027	114.53
37	92368	1.80	82	35372	97.27	37	1426748	2.55	82	405569	126.45
38	92202	1.91	83	31931	107.73	38	1423110	2.66	83	354285	140.05
39	92026	2.06	84	28491	119.23	39	1419325	2.81	84	304667	155.00
40	91836	2.21	85	25094	131.61	40	1415337	2.96	85	257444	171.09
41	91633	2.38	86	21791	144.68	41	1411148	3.13	86	213398	188.08
42	91415	2.57	87	18638	158.40	42	1406731	3.34	87	173262	205.92
43	91180	2.76	88	15686	172.60	43	1402033	3.59	88	137584	224.38
44	90928	2.96	89	12979	187.46	44	1397000	3.85	89	106713	243.70
45	90659	3.19	90	10546	203.08	45	1391622	4.15	90	80707	264.00
46	90370	3.43	91	8404	219.76	46	1385847	4.46	91	59400	285.69
47	90060	3.69	92	6557	238.20	47	1379666	4.80	92	42430	309.66
48	89728	3.98	93	4995	259.26	48	1373044	5.17	93	29291	337.04
49	89371	4.28	94	3700	285.17	49	1365945	5.56	94	19419	370.72
50	88988	4.62	95	2645	322.03	50	1358350	6.01	95	12220	418.64
51	88577	5.00	96	1793	378.56	51	1350186	6.50	96	7104	492.13
52	88134	5.46	97	1114	476.70	52	1341410	7.10	97	3608	619.71
53	87653	5.96	98	583	657.10	53	1331886	7.75	98	1372	854.23
54	87131	6.52	99	200	1000.00	54	1321564	8.48	99	200	1000.00
55	86563	7.14				55	1310357	9.28			
56	85945	7.80				56	1298197	10.14			
57	85275	8.51				57	1285033	11.06			
58	84549	9.24				58	1270821	12.01			
59	83768	10.05				59	1255558	13.07			

[#]Age nearest birthday

1980 CSO-ND NON-SMOKER TABLE & 1980 CET-ND NON-SMOKER TABLE [#]

Pivotal Age is 45 *** Ratio of Male l_x to Total is 50%

1980 CSO-ND NON-SMOKER TABLE						1980 CET-ND NON-SMOKER TABLE					
Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$
15	87164	1.07	60	76137	10.55	15	1321831	1.82	60	1099327	13.72
16	87071	1.16	61	75334	11.53	16	1319425	1.91	61	1084244	14.99
17	86970	1.23	62	74465	12.66	17	1316905	1.98	62	1067991	16.46
18	86863	1.27	63	73522	14.01	18	1314298	2.02	63	1050412	18.21
19	86753	1.32	64	72492	15.56	19	1311643	2.07	64	1031284	20.23
20	86638	1.35	65	71364	17.24	20	1308928	2.10	65	1010421	22.41
21	86521	1.34	66	70134	19.07	21	1306179	2.09	66	987777	24.79
22	86405	1.34	67	68797	20.98	22	1303449	2.09	67	963290	27.27
23	86289	1.33	68	67354	22.99	23	1300725	2.08	68	937021	29.89
24	86174	1.33	69	65806	25.15	24	1298019	2.08	69	909013	32.70
25	86059	1.30	70	64151	27.60	25	1295319	2.05	70	879288	35.88
26	85947	1.30	71	62380	30.69	26	1292664	2.05	71	847739	39.90
27	85835	1.29	72	60466	33.75	27	1290014	2.04	72	813914	43.88
28	85724	1.31	73	58425	37.67	28	1287382	2.06	73	778199	48.97
29	85612	1.33	74	56224	42.16	29	1284730	2.08	74	740091	54.81

30	85498	1.34	75	53854	47.06	30	1282058	2.09	75	699527	61.18
31	85383	1.37	76	51320	52.38	31	1279378	2.12	76	656730	68.09
32	85266	1.40	77	48632	57.96	32	1276666	2.15	77	612013	75.35
33	85147	1.45	78	45813	63.84	33	1273921	2.20	78	565898	82.99
34	85024	1.51	79	42888	70.16	34	1271118	2.26	79	518934	91.21
35	84896	1.58	80	39879	77.18	35	1268245	2.33	80	471602	100.33
36	84762	1.67	81	36801	85.11	36	1265290	2.42	81	424286	110.64
37	84620	1.77	82	33669	94.17	37	1262228	2.52	82	377343	122.42
38	84470	1.90	83	30498	104.54	38	1259047	2.65	83	331149	135.90
39	84310	2.03	84	27310	115.93	39	1255711	2.78	84	286146	150.71
40	84139	2.19	85	24144	128.27	40	1252220	2.94	85	243021	166.75
41	83955	2.36	86	21047	141.31	41	1248538	3.11	86	202497	183.70
42	83757	2.55	87	18073	155.09	42	1244655	3.32	87	165298	201.62
43	83543	2.73	88	15270	169.35	43	1240523	3.55	88	131971	220.16
44	83315	2.93	89	12684	184.40	44	1236119	3.81	89	102916	239.72
45	83071	3.16	90	10345	200.23	45	1231409	4.11	90	78245	260.30
46	82808	3.39	91	8274	217.23	46	1226348	4.41	91	57878	282.40
47	82527	3.65	92	6477	235.91	47	1220940	4.75	92	41533	306.68
48	82226	3.92	93	4949	257.43	48	1215141	5.10	93	28796	334.66
49	81904	4.22	94	3675	283.81	49	1208944	5.49	94	19159	368.95
50	81558	4.55	95	2632	320.74	50	1202307	5.92	95	12090	416.96
51	81187	4.92	96	1788	377.93	51	1195189	6.40	96	7049	491.31
52	80788	5.36	97	1112	476.61	52	1187540	6.97	97	3586	619.59
53	80355	5.85	98	582	656.44	53	1179263	7.61	98	1364	853.37
54	79885	6.38	99	200	1000.00	54	1170289	8.29	99	200	1000.00
55	79375	6.97				55	1160587	9.06			
56	78822	7.60				56	1150072	9.88			
57	78223	8.26				57	1138709	10.74			
58	77577	8.95				58	1126479	11.64			
59	76883	9.70				59	1113367	12.61			

[#]Age nearest birthday

1980 CSO-NE NON-SMOKER TABLE & 1980 CET-NE NON-SMOKER TABLE [#]

Pivotal Age is 45 *** Ratio of Male l_x to Total is 40%

1980 CSO-NE NON-SMOKER TABLE						1980 CET-NE NON-SMOKER TABLE					
Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$
15	80445	1.03	60	70486	10.14	15	1182241	1.78	60	986910	13.18
16	80362	1.10	61	69771	11.04	16	1180137	1.85	61	973903	14.35
17	80274	1.17	62	69001	12.12	17	1177954	1.92	62	959927	15.76
18	80180	1.21	63	68165	13.40	18	1175692	1.96	63	944799	17.42
19	80083	1.25	64	67252	14.89	19	1173388	2.00	64	928341	19.36
20	79983	1.29	65	66251	16.49	20	1171041	2.04	65	910368	21.44
21	79880	1.28	66	65159	18.23	21	1168652	2.03	66	890850	23.70
22	79778	1.28	67	63971	20.04	22	1166280	2.03	67	869737	26.05
23	79676	1.28	68	62689	21.93	23	1163912	2.03	68	847080	28.51

24	79574	1.28	69	61314	23.96	24	1161549	2.03	69	822930	31.15
25	79472	1.26	70	59845	26.28	25	1159191	2.01	70	797296	34.16
26	79372	1.26	71	58272	29.16	26	1156861	2.01	71	770060	37.91
27	79272	1.27	72	56573	32.11	27	1154536	2.02	72	740867	41.74
28	79171	1.28	73	54756	35.90	28	1152204	2.03	73	709943	46.67
29	79070	1.30	74	52790	40.21	29	1149865	2.05	74	676810	52.27
30	78967	1.31	75	50667	44.98	30	1147508	2.06	75	641433	58.47
31	78864	1.36	76	48388	50.15	31	1145144	2.11	76	603928	65.20
32	78757	1.39	77	45961	55.59	32	1142728	2.14	77	564552	72.27
33	78648	1.42	78	43406	61.36	33	1140283	2.17	78	523752	79.77
34	78536	1.49	79	40743	67.55	34	1137809	2.24	79	481972	87.82
35	78419	1.56	80	37991	74.48	35	1135260	2.31	80	439645	96.82
36	78297	1.65	81	35161	82.32	36	1132638	2.40	81	397079	107.02
37	78168	1.76	82	32267	91.29	37	1129920	2.51	82	354584	118.68
38	78030	1.87	83	29321	101.59	38	1127084	2.62	83	312502	132.07
39	77884	2.02	84	26342	112.91	39	1124131	2.77	84	271230	146.78
40	77727	2.16	85	23368	125.24	40	1121017	2.91	85	231419	162.81
41	77559	2.34	86	20441	138.25	41	1117755	3.09	86	193742	179.73
42	77378	2.53	87	17615	152.08	42	1114301	3.29	87	158921	197.70
43	77182	2.72	88	14936	166.50	43	1110635	3.54	88	127502	216.45
44	76972	2.91	89	12449	181.73	44	1106703	3.78	89	99904	236.25
45	76748	3.13	90	10187	197.78	45	1102520	4.07	90	76302	257.11
46	76508	3.35	91	8172	215.12	46	1098033	4.36	91	56684	279.66
47	76252	3.59	92	6414	234.03	47	1093246	4.67	92	40832	304.24
48	75978	3.87	93	4913	255.85	48	1088141	5.03	93	28409	332.61
49	75684	4.15	94	3656	282.58	49	1082668	5.40	94	18960	367.35
50	75370	4.48	95	2623	319.76	50	1076822	5.82	95	11995	415.69
51	75032	4.84	96	1784	377.41	51	1070555	6.29	96	7009	490.63
52	74669	5.25	97	1111	476.21	52	1063821	6.83	97	3570	619.07
53	74277	5.73	98	582	656.10	53	1056555	7.45	98	1360	852.93
54	73851	6.23	99	200	1000.00	54	1048684	8.10	99	200	1000.00
55	73391	6.81				55	1040190	8.85			
56	72891	7.39				56	1030984	9.61			
57	72352	8.02				57	1021076	10.43			
58	71772	8.65				58	1010426	11.25			
59	71151	9.35				59	999059	12.16			

[#]Age nearest birthday

1980 CSO-NF NON-SMOKER TABLE & 1980 CET-NF NON-SMOKER TABLE [#]

Pivotal Age is 45 *** Ratio of Male l_x to Total is 20%

1980 CSO-NF NON-SMOKER TABLE						1980 CET-NF NON-SMOKER TABLE					
Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$	Age	l_x	$1000q_x$
15	69713	0.94	60	61464	9.32	15	974349	1.69	60	819503	12.12
16	69647	0.99	61	60891	10.11	16	972702	1.74	61	809571	13.14
17	69578	1.04	62	60275	11.04	17	971009	1.79	62	798933	14.35

18	69506	1.07	63	59610	12.20	18	969271	1.82	63	787468	15.86
19	69432	1.12	64	58883	13.55	19	967507	1.87	64	774979	17.62
20	69354	1.15	65	58085	15.01	20	965698	1.90	65	761324	19.51
21	69274	1.14	66	57213	16.58	21	963863	1.89	66	746471	21.55
22	69195	1.16	67	56264	18.21	22	962041	1.91	67	730385	23.67
23	69115	1.16	68	55239	19.86	23	960204	1.91	68	713097	25.82
24	69035	1.18	69	54142	21.65	24	958370	1.93	69	694685	28.15
25	68954	1.17	70	52970	23.69	25	956520	1.92	70	675130	30.80
26	68873	1.19	71	51715	26.19	26	954683	1.94	71	654336	34.05
27	68791	1.20	72	50361	28.98	27	952831	1.95	72	632056	37.67
28	68708	1.23	73	48902	32.47	28	950973	1.98	73	608246	42.21
29	68623	1.25	74	47314	36.50	29	949090	2.00	74	582572	47.45
30	68537	1.28	75	45587	41.02	30	947192	2.03	75	554929	53.33
31	68449	1.32	76	43717	45.94	31	945269	2.07	76	525335	59.72
32	68359	1.35	77	41709	51.16	32	943312	2.10	77	493962	66.51
33	68267	1.38	78	39575	56.73	33	941331	2.13	78	461109	73.75
34	68173	1.45	79	37330	62.78	34	939326	2.20	79	427102	81.61
35	68074	1.51	80	34986	69.53	35	937259	2.26	80	392246	90.39
36	67971	1.61	81	32553	77.24	36	935141	2.36	81	356791	100.41
37	67862	1.71	82	30039	86.13	37	932934	2.46	82	320966	111.97
38	67746	1.84	83	27452	96.33	38	930639	2.59	83	285027	125.23
39	67621	1.97	84	24808	107.59	39	928229	2.72	84	249333	139.87
40	67488	2.12	85	22139	119.91	40	925704	2.87	85	214459	155.88
41	67345	2.30	86	19484	132.99	41	923047	3.05	86	181029	172.89
42	67190	2.49	87	16893	146.95	42	920232	3.24	87	149731	191.04
43	67023	2.67	88	14411	161.59	43	917250	3.47	88	121126	210.07
44	66844	2.85	89	12082	177.21	44	914067	3.71	89	95681	230.37
45	66653	3.06	90	9941	193.74	45	910676	3.98	90	73639	251.86
46	66449	3.27	91	8015	211.49	46	907052	4.25	91	55092	274.94
47	66232	3.50	92	6320	231.05	47	903197	4.55	92	39945	300.37
48	66000	3.76	93	4860	253.44	48	899087	4.89	93	27947	329.47
49	65752	4.02	94	3628	280.66	49	894690	5.23	94	18739	364.86
50	65488	4.33	95	2610	318.37	50	890011	5.63	95	11902	413.88
51	65204	4.67	96	1779	376.21	51	885000	6.07	96	6976	489.07
52	64899	5.05	97	1110	475.72	52	879628	6.57	97	3564	618.44
53	64571	5.49	98	582	656.09	53	873849	7.14	98	1360	852.92
54	64217	5.96	99	200	1000.00	54	867610	7.75	99	200	1000.00
55	63834	6.46				55	860886	8.40			
56	63422	6.99				55	853655	9.09			
57	62979	7.54				57	845895	9.80			
58	62504	8.06				58	837605	10.48			
59	62000	8.65				59	828827	11.25			

[#]Age nearest birthday

(Department of Insurance; 760 IAC 1-32-10; filed Jul 16, 1987, 3:20 pm: 10 IR 2705; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 33. Variable Life Insurance

760 IAC 1-33-1 Authority

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7; IC 27-1-5-1; IC 27-1-12-7

Sec. 1. 760 IAC 1-33 applicable to variable life insurance policies is promulgated under the authority of IC 27-1-3-7 of the insurance laws of Indiana, and is effective upon promulgation. *(Department of Insurance; 760 IAC 1-33-1; filed Mar 29, 1985, 1:46 pm: 8 IR 1014; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-33-2 Definitions

Authority: IC 27-1-3-7
Affected: IC 27-1-5-1; IC 27-1-12-7

Sec. 2. As used in 760 IAC 1-33: (a) "Affiliate" of an insurer means any person, directly or indirectly, controlling, controlled by, or under common control with such insurer; any person who regularly furnishes investment advice to such insurer with respect to its separate accounts for which a specific fee or commission is charged; or any director, officer, partner, or employee of any such insurer, controlling or controlled person, or person providing investment advice or any member of the immediate family of such person.

(b) "Agent" means any person, corporation, partnership, or other legal entity which is licensed by this state as a life insurance agent.

(c) "Assumed investment rate" means the rate of investment return which would be required to be credited to a variable life insurance policy, after deduction of charges for taxes, investment expenses, and mortality and expense guarantees to maintain the variable death benefit equal at all times to the amount of death benefit, other than incidental insurance benefits, which would be payable under the plan of insurance if the death benefit did not vary according to the investment experience of the separate account.

(d) "Benefit base" means the amount, to which the net investment return is applied.

(e) "Commissioner" means the insurance commissioner of this state.

(f) "Control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing more than ten percent (10%) of the voting securities of any other person. This presumption may be rebutted by a showing made to the satisfaction of the commissioner that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and make specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(g) "Flexible premium policy" means any variable life insurance policy other than a scheduled premium policy as specified in (o).

(h) "General account" means all assets of the insurer other than assets in separate accounts established pursuant to IC 27-1-5-1 Class 1(c) of the insurance laws of this state, or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer, whether or not for variable life insurance.

(i) "Incidental insurance benefit" means all insurance benefits in a variable life insurance policy, other than the variable death benefit and the minimum death benefit, including but not limited to accidental death and dismemberment benefits, disability benefits, guaranteed insurability options, family income, or term riders.

(j) "May" is permissive.

(k) "Minimum death benefit" means the amount of the guaranteed death benefit, other than incidental insurance benefits, payable under a variable life insurance policy regardless of the investment performance of the separate account.

(l) "Net investment return" means the rate of investment return in a separate account to be applied to the benefit base.

(m) "Person" means an individual, corporation, partnership, association, trust, or fund.

(n) "Policy processing day" means the day on which charges authorized in the policy are deducted from the policy's cash value.

(o) "Scheduled premium policy" means any variable life insurance policy under which both the amount and timing of premium payments are fixed by the insurer.

(p) "Separate account" means a separate account established pursuant to IC 27-1-5-1 Class 1(c) of the insurance laws of this state or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

(q) "Shall" is mandatory.

(r) "Variable death benefit" means the amount of the death benefit, other than incidental insurance benefits, payable under a variable life insurance policy dependent on the investment performance of the separate account, which the insurer would have to pay in the absence of any minimum death benefit.

(s) "Variable life insurance policy" means any individual policy which provides for life insurance the amount or duration of which varies according to the investment experience of any separate account or accounts established and maintained by the insurer as to such policy, pursuant to IC 27-1-5-1 Class 1(c) of the insurance laws of this state or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer. *(Department of Insurance; 760 IAC 1-33-2; filed Mar 29, 1985, 1:46 pm: 8 IR 1014; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-33-3 Qualification of insurers

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7

Sec. 3. The following requirements are applicable to all insurers either seeking authority to issue variable life insurance in this state or having authority to issue variable life insurance in this state.

(1) Licensing and approval to do business in this state. An insurer shall not deliver or issue for delivery in this state any variable life insurance policy unless:

(A) The insurer is licensed or organized to do a life insurance business in this state.

(B) The insurer has obtained the written approval of the commissioner for the issuance of variable life insurance policies in this state. The commissioner shall grant such written approval only after he has found that:

(i) The plan of operation for the issuance of variable life insurance policies is not unsound.

(ii) The general character, reputation, and experience of the management and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer are such as to reasonably assure competent operation of the variable life insurance business of the insurer in this state.

(iii) The present and forseeable future financial condition of the insurer and its method of operation in connection with the issuance of such policies is not likely to render its operation hazardous to the public or its policyholders in this state. The commissioner shall consider, among other things:

(AA) The history of operation and financial condition of the insurer.

(BB) The qualifications, fitness, character, responsibility, reputation, and experience of the officers and directors and other management of the insurer and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer.

(CC) The applicable law and regulations under which the insurer is authorized in its state of domicile to issue variable life insurance policies. The state of entry of an alien insurer shall be deemed its state of domicile for this purpose.

(DD) If the insurer is a subsidiary of, or is affiliated by common management or ownership with another company, its relationship to such other company and the degree to which the requesting insurer, as well as the other company, meet these standards.

(2) Filing for approval to do business in this state. The commissioner may, at his discretion, require that an insurer, before it delivers or issues for delivery any variable life insurance policy in this state, file with this department the following information for the consideration of the commissioner in making the determination required by (1)(B):

(A) Copies of and a general description of the variable life insurance policies it intends to issue.

(B) A general description of the methods of operation of the variable life insurance business of the insurer, including methods of distribution of policies and the names of those persons or firms proposed to supply consulting, investment, administrative, custodial or distribution services to the insurer.

(C) With respect to any separate account maintained by an insurer for any variable life insurance policy, a statement

of the investment policy the issuer intends to follow for the investment of the assets held in such separate account, and a statement of procedures for changing such investment policy. The statement of investment policy shall include a description of the investment objectives intended for the separate account.

(D) A description of any investment advisory services contemplated as required by 760 IAC 1-33-6(k).

(E) A copy of the statutes and regulations of the state of domicile of the insurer under which it is authorized to issue variable life insurance policies.

(F) Biographical data with respect to officers and directors of the insurer on the National Association of Insurance Commissioners Uniform Biographical Data Form.

(G) A statement of the insurer's actuary describing the mortality and expense risks which the insurer will bear under the policy.

(3) Standards of suitability. Every insurer seeking approval to enter into the variable life insurance business in this state shall establish and maintain a written statement specifying the standards of suitability to be used by the insurer. Such standards of suitability shall specify that no recommendations shall be made to an applicant to purchase a variable life insurance policy and that no variable life insurance policy shall be issued in the absence of reasonable grounds to believe that the purchase of such policy is not unsuitable for such applicant on the basis of information furnished after reasonable inquiry of such applicant concerning the applicant's insurance and investment objectives, financial situation and needs, and any other information known to the insurer or to the agent making the recommendation.

(4) Use of sales materials. An insurer authorized to transact variable life insurance business in this state shall not use any sales material, advertising material, or descriptive literature or other materials of any kind in connection with its variable life insurance business in this state which is false, misleading, deceptive, or inaccurate.

(5) Requirements applicable to contractual services. Any material contract between an insurer and suppliers of consulting, investment, administrative, sales, marketing, custodial, or other services with respect to variable life insurance operations shall be in writing and provide that the supplier of such services shall furnish the commissioner with any information or reports in connection with such services which the commissioner may request in order to ascertain whether the variable life insurance operations of the insurer are being conducted in a manner consistent with 760 IAC 1-33 and any other applicable law or regulations.

(6) Reports to the commissioner. Any insurer authorized to transact the business of variable life insurance in this state shall submit to the commissioner, in addition to any other materials which may be required by 760 IAC 1-33 or any other applicable laws or regulations:

(A) an annual statement of the business of its separate account or accounts in such form as may be prescribed by the National Association of Insurance Commissioner *[sic.]*; and

(B) prior to the use in this state any information furnished to applicants as provided for in 760 IAC 1-33-7; and

(C) prior to the use in this state the form of any of the reports to policyholders as provided for in 760 IAC 1-33-9; and

(D) such additional information concerning its variable life insurance operations or its separate accounts as the commissioner shall deem necessary.

Any material submitted to the commissioner under this section shall be disapproved if it is found to be false, misleading, deceptive, or inaccurate in any material respect and, if previously distributed, the commissioner shall require the distribution of amended material.

(7) Authority of commissioner to disapprove. Any material required to be filed with an *[sic.]* approved by the commissioner shall be subject to disapproval if at any time is found by him not to comply with the standards established by 760 IAC 1-33.

(Department of Insurance; 760 IAC 1-33-3; filed Mar 29, 1985, 1:46 pm: 8 IR 1015; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-33-4 Insurance policy requirements

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7; IC 27-1-12.3-1

Sec. 4. Policy qualification. The commissioner shall not approve any variable life insurance form filed pursuant to 760 IAC 1-33 unless it conforms to the requirements of this section.

(b) Filing of variable life insurance policies. All variable life insurance policies, and all riders, endorsements, applications,

and other documents which are to be attached to and made a part of the policy and which relate to the variable nature of the policy, shall be filed with the commissioner and approved by him prior to delivery or issuance for delivery in this state.

(1) The procedures and requirements for such filing and approval shall be, to the extent appropriate and not inconsistent with 760 IAC 1-33, the same as those otherwise applicable to other life insurance policies.

(2) The commissioner may approve variable life insurance policies and related forms with provisions the commissioner deems to be not less favorable to the policyholder and the beneficiary than those required by 760 IAC 1-33.

(c) Mandatory policy benefit and design requirements. Variable life insurance policies delivered or issued for delivery in this state shall comply with the following minimum requirements:

(1) Mortality and expense risks shall be borne by the insurer. The mortality and expense charges shall be subject to the maximums stated in the contract.

(2) For scheduled premium policies, a minimum death benefit shall be provided in an amount at least equal to the initial face amount of the policy so long as premiums are duly paid (subject to the provisions of (e)).

(3) The policy shall reflect the investment experience of one (1) or more separate accounts established and maintained by the insurer. The insurer must demonstrate that the variable life insurance policy is actuarially sound.

(4) Each variable life insurance policy shall be credited with the full amount of the net investment return applied to the benefit base.

(5) Any changes in variable death benefits of each variable life insurance policy shall be determined at least annually.

(6) The cash value of each variable life insurance policy shall be determined at least monthly. The method of computation of cash values and other non-forfeiture benefits, as described either in the policy or in a statement filed with the commissioner of the state in which the policy is delivered, or issued for delivery, shall be in accordance with actuarial procedures that recognize the variable nature of the policy. The method of computation must be such that, if the net investment return credited to the policy at all times from the date of issue should be equal to the assumed investment rate with premiums and benefits determined accordingly under the terms of the policy, then the resulting cash values and other non-forfeiture benefits must be at least equal to the minimum values required by IC 27-1-12-7 of the insurance laws of this state (standard non-forfeiture law) for a general account policy with such premiums and benefits. The assumed investment rate shall not exceed the maximum interest rate permitted under the standard non-forfeiture law of this state. If the policy does not contain an assumed investment rate this demonstration shall be based on the maximum interest rate permitted under the standard non-forfeiture law. The method of computation may disregard incidental minimum guarantees as to the dollar amounts payable. Incidental minimum guarantees include, for example, but are not to be limited to, a guarantee that the amount payable at death or maturity shall be at least equal to the amount that otherwise would have been payable if the net investment return credited to the policy at all times from the date of issue had been equal to the assumed investment rate.

(7) The computation of values required for each variable life insurance policy may be based upon such reasonable and necessary approximations as are acceptable to the commissioner.

(d) Mandatory policy provisions. Every variable life insurance policy filed for approval in this state shall contain at least the following:

(1) The cover page or pages corresponding to the cover pages of each such policy shall contain:

(A) A prominent statement in either contrasting color or in boldface type that the amount or duration of death benefits may be variable or fixed under specified conditions.

(B) A prominent statement in either contrasting color or in boldface type that cash values may increase or decrease in accordance with the experience of the separate account subject to any specified minimum guarantees.

(C) A statement describing any minimum death benefit required pursuant to (c)(2).

(D) The method, or a reference to the policy provision which describes the method, for determining the amount of insurance payable at death.

(E) To the extent permitted by state law, a captioned provision that the policyholder may return the variable life insurance policy within ten (10) days of receipt of the policy by the policyholder, and receive a refund equal to the sum of (i) the difference between the premiums paid including any policy fees or other charges and the amounts allocated to any separate accounts under the policy and (ii) the value of the amounts allocated to any separate accounts under the policy, on the date the returned policy is received by the insurer or its agent. Until such time as state law authorizes the return of payments as calculated in the preceding sentence, the amount of the refund shall be the total of all premium payments for such policy.

(F) Such other items as are currently required for fixed benefit life insurance policies and which are not inconsistent with 760 IAC 1-33.

(2)(A) For scheduled premium policies, a provision for a grace period of not less than thirty-one (31) days from the premium due date which shall provide that where the premium is paid within the grace period, policy values will be the same, except for the deduction of any overdue premium, as if the premium were paid on or before the due date.

(B) For flexible premium policies, a provision for a grace period beginning on the policy processing day when the total charges authorized by the policy that are necessary to keep the policy in force until the next policy processing day exceed the amounts available under the policy to pay such charges in accordance with the terms of the policy. Such grace period shall end on a date not less than sixty-one (61) days after the mailing date of the report to policyholders required by 760 IAC 1-33-9(3).

The death benefit payable during the grace period will equal the death benefit in effect immediately prior to such period less any overdue charges. If the policy processing days occur monthly, the insurer may require the payment of not more than three (3) times the charges which were due on the policy processing day on which the amounts available under the policy were insufficient to pay all charges authorized by the policy that are necessary to keep such policy in force until the next policy processing day.

(3) For scheduled premium policies, a provision that the policy will be reinstated at any time within two (2) years from the date of default upon the written application of the insured and evidence of insurability, including good health, satisfactory to the insurer, unless the cash surrender value has been paid or the period of extended insurance has expired, upon the payment of any outstanding indebtedness arising subsequent to the end of the grace period following the date of default together with accrued interest thereon to the date of reinstatement and payment of an amount not exceeding the greater of:

(A) All overdue premiums with interest at a specified rate and any indebtedness in effect at the end of the grace period following the date of default with interest at a rate specified in IC 27-1-12.3 et seq.; or

(B) 110% of the increase in cash value resulting from reinstatement plus all overdue premiums for incidental insurance benefits with interest at a specified rate.

(4) A full description of the benefit base and of the method of calculation and application of any factors used to adjust variable benefits under the policy.

(5) A provision designating the separate account to be used and stating that:

(A) The assets of such separate account shall be available to cover the liabilities of the general account of the insurer only to the extent that the assets of the separate account exceed the liabilities of the separate account arising under the variable life insurance policies supported by the separate account.

(B) The assets of such separate account shall be valued at least as often as any policy benefits vary but at least monthly.

(6) A provision specifying what documents constitute the entire insurance contract under state law.

(7) A designation of the officers who are empowered to make an agreement or representation on behalf of the insurer and an indication that statements by the insured, or on his behalf, shall be considered as representations and not warranties.

(8) An identification of the owner of the insurance contract.

(9) A provision setting forth conditions or requirements as to the designation, or change of designation, of a beneficiary and a provision for disbursement of benefits in the absence of a beneficiary designation.

(10) A statement of any conditions or requirements concerning the assignment of the policy.

(11) A description of any adjustments in policy values to be made in the event of misstatement of age or sex of the insured.

(12) A provision that the policy shall be incontestable by the insurer after it has been in force for two (2) years during the lifetime of the insured, provided, however, that any increase in the amount of the policy's death benefits subsequent to the policy issue date, which increase occurred upon a new application or request of the owner and was subject to satisfactory proof of the insured's insurability, shall be incontestable after any such increase has been in force, during the lifetime of the insured, for two (2) years from the date of issue of such increase.

(13) A provision stating that the investment policy of the separate account shall not be changed without the approval of the insurance commissioner of the state of domicile of the insurer, and that the approval process is on file with the commissioner of this state.

(14) A provision that payment of variable death benefits in excess of any minimum death benefits, cash values, policy loans, or partial withdrawals (except when used to pay premiums) or partial surrenders may be deferred:

(A) for up to six (6) months from the date of request, if such payments are based on policy values which do not depend

on the investment performance of the separate account; or

(B) otherwise, for any period during which the New York Stock Exchange is closed for trading (except for normal holiday closing) or when the Securities and Exchange Commission has determined that a state of emergency exists which may make such payment impractical.

(15) If settlement options are provided, at least one (1) such option shall be provided on a fixed basis only.

(16) A description of the basis for computing the cash value and the surrender value under the policy shall be included.

(17) Premiums or charges for incidental insurance benefits shall be stated separately.

(18) Any other policy provision required by 760 IAC 1-33.

(19) Such other items as are currently required for fixed benefit life insurance policies and are not inconsistent with 760 IAC 1-33.

(20) A provision for non-forfeiture insurance benefits. The insurer may establish a reasonable minimum cash value below which any non-forfeiture insurance options will not be available.

(e) Policy loan provisions. Every variable life insurance policy, other than term insurance policies and pure endowment policies, delivered or issued for delivery in this state shall contain provisions which are not less favorable to the policyholder than the following:

A provision for policy loans (which may at the option of the insurer be entitled and referred to as a partial withdrawal provision) not less favorable to the policyholder than the following:

(1) At least seventy-five percent (75%) of the policy's cash surrender value may be borrowed.

(2) The amount borrowed shall bear interest at a rate not to exceed that permitted by state insurance law.

(3) Any indebtedness shall be deducted from the proceeds payable on death.

(4) Any indebtedness shall be deducted from the cash surrender value upon surrender or in determining any non-forfeiture benefit.

(5) For scheduled premium policies, whenever the indebtedness exceeds the cash surrender value, the insurer shall give notice of any intent to cancel the policy if the excess indebtedness is not repaid within thirty-one (31) days after the date of mailing of such notice. For flexible premium policies, whenever the total charge authorized by the policy that are necessary to keep the policy in force until the next following processing day exceed the amounts available under the policy to pay such charges, a report must be sent to the policyholder containing the information specified by 760 IAC 1-33-9(3).

(6) The policy may provide that if, at any time, so long as premiums are duly paid, the variable death benefit is less than it would have been if no loan or withdrawal had ever been made, the policyholder may increase such variable death benefit up to what it would have been if there had been no loan or withdrawal by paying an amount not exceeding 110% of the corresponding increase in cash value and by furnishing such evidence of insurability as the insurer may request.

(7) The policy may specify a reasonable minimum amount which may be borrowed at any time but such minimum shall not apply to any automatic premium loan provision.

(8) No policy loan provision is required if the policy is under extended insurance non-forfeiture option.

(9) The policy loan provisions shall be constructed so that variable life insurance policyholders who have not exercised such provisions are not disadvantaged by the exercise thereof.

(10) Amounts paid to the policyholders upon the exercise of any policy loan provision shall be withdrawn from the separate account and shall be returned to the separate account upon repayment except that a stock insurer may provide the amounts for policy loans from the general account.

(f) Other policy provisions. The following provisions may in substance be included in a variable life insurance policy or related form delivered or issued for delivery in this state:

(1) An exclusion for suicide within two (2) years of the issue date of the policy; provided, however, that to the extent of the increased death benefits only, the policy may provide an exclusion for suicide within two (2) years of any increase in death benefits which results from an application of the owner subsequent to the policy issue date.

(2) Incidental insurance benefits may be offered on a fixed or variable basis.

(3) Policies issued on a participating basis shall offer to pay dividend amounts in cash. In addition, such policies may offer the following dividend options:

(A) the amount of the dividend may be credited against premium payments;

(B) the amount of the dividend may be applied to provide amounts of additional fixed or variable benefit life insurance;

(C) the amount of the dividend may be deposited in the general account at a specified minimum rate of interest;

(D) the amount of the dividend may be applied to provide paid-up amounts of fixed benefit one-year term insurance;

(E) the amount of the dividend may be deposited as a variable deposit in a separate account.

(4) A provision allowing the policyholder to elect in writing in the application for the policy or thereafter an automatic premium loan on a basis not less favorable than that required of policy loans under (e), except that a restriction that no more than two (2) consecutive premiums can be paid under this provision may be imposed.

(5) A provision allowing the policyholder to make partial withdrawals.

(6) Any other policy provision approved by the commissioner.

(Department of Insurance; 760 IAC 1-33-4; filed Mar 29, 1985, 1:46 pm: 8 IR 1017; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-33-5 Reserve liabilities for variable life insurance

Authority: IC 27-1-3-7

Affected: IC 27-1-12-7

Sec. 5. (a) Reserve liabilities for variable life insurance policies shall be established under the standard valuation law in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

(b) For scheduled premium policies, reserve liabilities for the guaranteed minimum death benefit shall be the reserve needed to provide for the contingency of death occurring when the guaranteed minimum death benefit exceeds the death benefit that would be paid in the absence of the guarantee, and shall be maintained in the general account of the insurer and shall be not less than the greater of the following minimum reserves:

(1) the aggregate total of the term costs, if any, covering a period of one (1) full year from the valuation date, of the guarantee on each variable life insurance contract, assuming an immediate one-third (1/3) depreciation in the current value of the assets of the separate account followed by a net investment return equal to the assumed investment rate; or

(2) the aggregate total of the "attained age level" reserves on each variable life insurance contract. The "attained age level" reserve on each variable life insurance contract shall not be less than zero (0) and shall equal the "residue," as described in (2)(A), of the prior year's "attained age level" reserve on the contract, with any such "residue," increased or decreased by a payment computed on an attained age basis as described in (2)(B);

(A) The "residue" of the prior year's "attained age level" reserve on each variable life insurance contract shall not be less than zero (0) and shall be determined by adding interest at the valuation interest rate to such prior year's reserve, deducting the tabular claims based on the "excess," if any, of the guaranteed minimum death benefit over the death benefit that would be payable in the absence of such guarantee, and dividing the net result by the tabular probability of survival. The "excess" referred to in the preceding sentence shall be based on the actual level of death benefits that would have been in effect during the preceding year in the absence of the guarantee, taking appropriate account of the reserve assumptions regarding the distribution of death claim payments over the year.

(B) The payment referred to in (b)(2) shall be computed so that the present value of a level payment of that amount each year over the future premium paying period of the contract is equal to (A) minus (B) minus (C), where (A) is present value of the future guaranteed minimum death benefits, (B) is the present value of the future death benefits that would be payable in the absence of such guarantee, and (C) is any "residue," as described in (2)(A), of the prior year's "attained age level" reserve on such variable life insurance contract. If the contract is paid up, the payment shall equal (A) minus (B) minus (C). The amounts of future death benefits referred to in (B) shall be computed assuming a net investment return of the separate account which may differ from the assumed investment rate and/or the valuation interest rate but in no event may exceed the maximum interest rate permitted for the valuation of life contracts.

(3) The valuation interest rate and mortality table used in computing the two minimum reserves described in (1) and (2) above shall conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the company may employ suitable approximations and estimates, including but not limited to groupings and averages.

(c) For flexible premium policies, reserve liabilities for any guaranteed minimum death benefit shall be maintained in the general account of the insurer and shall be not less than the aggregate total of the term costs, if any, covering the period provided for in the guarantee not otherwise provided for by the reserves held in the separate account assuming an immediate one-third (1/3) depreciation in the current value of the assets of the separate account followed by a net investment return equal to the valuation interest rate.

The valuation interest rate and mortality table used in computing this additional reserve, if any, shall conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the company may employ suitable approximations and estimates, including but not limited to groupings and averages.

(d) Reserve liabilities for all fixed incidental insurance benefits and any guarantees associated with variable incidental insurance benefits shall be maintained in the general account and reserve liabilities for all variable aspects of the variable incidental insurance benefits *[sic.]* shall be maintained in a separate account, in amounts determined in accordance with the actuarial procedures appropriate to such benefit. *(Department of Insurance; 760 IAC 1-33-5; filed Mar 29, 1985, 1:46 pm: 8 IR 1020; filed Aug 30, 1985, 1:45 pm: 9 IR 59; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-33-6 Separate accounts

Authority: IC 27-1-3-7
Affected: IC 27-1-5-1; IC 27-1-12-7

Sec. 6. (a) The following requirements apply to the establishment and administration of variable life insurance separate accounts by any domestic insurer.

(b) Establishment and administration of separate accounts. Any domestic insurer issuing variable life insurance shall establish one (1) or more separate accounts pursuant to IC 27-1-5-1 Class 1(c) of the insurance law of this state.

(1) If no law or other regulation provides for the custody of separate account assets and if such insurer is not the custodian of such separate account assets, all contracts for custody of such assets shall be in writing and the commissioner shall have authority to review and approve of both the terms of any such contract and the proposed custodian prior to the transfer of custody.

(2) Such insurer shall not without the prior written approval of the commissioner employ in any material connection with the handling of separate account asset any person who:

(A) within the last ten (10) years has been convicted of any felony or a misdemeanor arising out of such person's conduct involving embezzlement, fraudulent conversion, or misappropriation of funds or securities or involving violation of Sections 1341, 1342, or 1343 of Title 18, United States Code; or

(B) within the last ten (10) years has been found by any state regulatory authority to have violated or has acknowledged violation of any provision of any state insurance law involving fraud, deceit, or knowing misrepresentation; or

(C) within the last ten (10) years has been found by federal or state regulatory authorities to have violated or has acknowledged violation of any provision of federal or state securities laws involving fraud, deceit, or knowing misrepresentation.

(3) All persons with access to the cash, securities, or other assets of the separate account shall be under bond in the amount of not less than $10,000.

(4) The assets of such separate accounts shall be valued at least as often as variable benefits are determined but in any event at least monthly.

(c) Amounts in the separate account. The insurer shall maintain in each separate account assets with a value at least equal to the greater of the valuation reserves for the variable portion of the variable life insurance policies or the benefit base for such policies.

(d) Investments by the separate account. (1) No sale, exchange, or other transfer of assets may be made by an insurer or any of its affiliates between any of its separate accounts or between any other investment account and one (1) or more of its separate accounts unless:

(A) in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the policies with respect to the separate account to which the transfer is made; and

(B) such transfer, whether into or from a separate account, is made by a transfer of cash; but other assets may be transferred if approved by the commissioner in advance.

(2) The separate account shall have sufficient net investment income and readily marketable assets to meet anticipated withdrawals under policies funded by the account.

(e) Limitations on ownership. (1) A separate account shall not purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal and interest by the United States, if immediately after such purchase or acquisition the value of such investment, together with prior investments of such account in such security valued as required by 760 IAC 1-33,

would exceed ten percent (10%) of the value of the assets of the separate account. The commissioner may waive this limitation in writing if he believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this state.

(2) No separate account shall purchase or otherwise acquire the voting securities of any issuer if as a result of such acquisition the insurer and its separate accounts, in the aggregate, will own more than ten percent (10%) of the total issued and outstanding voting securities of such issuer. The commissioner may waive this limitation in writing if he believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this state or jeopardize the independent operations of the issuer of such securities.

(3) The percentage limitation specified in (1) and (2) shall not be construed to preclude the investment of the assets of separate accounts in shares of investment companies registered pursuant to the Investment Company Act of 1940 or other pools of investment assets if the investments and investment policies of such investment companies or asset pools comply substantially with the provisions of (d) and other applicable portions of 760 IAC 1-33.

(f) Valuation of separate account assets. Investments of the separate account shall be valued at their market value on the date of valuation, or at amortized cost if it approximates market value.

(g) Separate account investment policy. The investment policy of a separate account operated by a domestic insurer filed under 760 IAC 1-33-3(2)(C) shall not be changed without first filing such change with the insurance commissioner.

(1) Any change filed pursuant to this section shall be effective sixty (60) days after the date it was filed with the commissioner, unless the commissioner notifies the insurer before the end of such sixty (60) day period of his disapproval of the proposed change. At any time the commissioner may, after notice and public hearing, disapprove any change that has become effective pursuant to this subsection.

(2) the commissioner may disapprove the change if he determined that the change would be detrimental to the interests of the policyholder participating in such separate account.

(h) Charges against separate account. The insurer must disclose in writing, prior to or contemporaneously with delivery of the policy, all charges that may be made against the separate account, including, but not limited to, the following:

(1) taxes or reserves for taxes attributable to investment gains and income of the separate account;

(2) actual cost of reasonable brokerage fees and similar direct acquisition and sale costs incurred in the purchase or sale of separate account assets;

(3) actuarially determined costs of insurance (tabular costs) and the release of separate account liabilities;

(4) charges for administrative expenses and investment management expenses, including internal costs attributable to the investment management of assets of the separate account;

(5) a charge, at a rate specified in the policy, for mortality and expense guarantees;

(6) any amounts in excess of those required to be held in the separate accounts;

(7) charges for incidental insurance benefits.

(i) Standards of conduct. Every insurer seeking approval to enter into the variable life insurance business in this state shall adopt by formal action of its board of directors a written statement specifying the standards of conduct of the insurer, its officers, directors, employees, and affiliates with respect to the purchase or sale of investments of separate accounts. Such standards of conduct shall be binding on the insurer and those to whom it refers. A code or codes of ethics meeting the requirements of Section 17j under the Investment Company Act of 1940 and applicable rules and regulations thereunder shall satisfy the provisions of this section.

(j) Conflicts of interest. Rules under any provision of the insurance laws of this state or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to members of any separate account's committee or other similar body.

(k)(a) Investment advisory services to a separate account. An insurer shall not enter into a contract under which any person undertakes, for a fee, to regularly furnish investment advice to such insurer with respect to its separate accounts maintained for variable life insurance policies unless:

(1) the person providing such advice is registered as an investment adviser under the Investment Advisers Act of 1940; or

(2) the person providing such advice is an investment manager under the Employee Retirement Income Security Act of 1974 with respect to the assets of each employee benefit plan allocated to the separate account; or

(3) the insurer has filed with the commissioner and continues to file annually the following information and statements concerning the proposed adviser:

(A) the name and form of organization, state of organization, and its principal place of business;

(B) the names and addresses of its partners, officers, directors, and persons performing similar functions or, if such an investment adviser be an individual, of such individual;

(C) a written standard of conduct complying in substance with the requirements of (i) which has been adopted by the investment adviser and is applicable to the investment adviser, his officers, directors, and affiliates;

(D) a statement provided by the proposed adviser as to whether the adviser or any person associated therewith:

(i) has been convicted within ten (10) years of any felony or misdemeanor arising out of such person's conduct as an employee, salesman, officer or director or an insurance company, a banker, an insurance agent, a securities broker, or an investment adviser involving embezzlement, fraudulent conversion, or misappropriation of funds or securities, or involving the violation of Sections 1341, 1342, or 1343 of Title 18 of the United States Code;

(ii) has been permanently or temporarily enjoined by order, judgment, or decree of any court of competent jurisdiction from acting as an investment adviser, underwriter, broker, or dealer, or as an affiliated person or as an employee of any investment company, bank, or insurance company or from engaging in or continuing any conduct or practice in connection with any such activity;

(iii) has been found by federal or state regulatory authorities to have willfully violated or have acknowledged willful violation of any provision of federal or state securities laws or state insurance laws or of any rule or regulation under any such laws; or

(iv) has been censured, denied an investment adviser registration, had a registration as an investment adviser revoked or suspended, or been barred or suspended from being associated with an investment adviser by order of federal or state regulatory authorities; and

(4) such investment advisory contract shall be in writing and provide that it may be terminated by the insurer without penalty to the insurer or the separate account upon no more than sixty (60) days' written notice to the investment adviser.

(b) The commissioner may, after notice and opportunity for hearing, by order require such investment advisory contract to be terminated if he deems continued operation thereunder to be hazardous to the public or the insurer's policyholders. *(Department of Insurance; 760 IAC 1-33-6; filed Mar 29, 1985, 1:46 pm: 8 IR 1021; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-33-7 Disclosures to applicants

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7

Sec. 7. An insurer delivering or issuing for delivery in this state any variable life insurance policies shall deliver to the applicant for the policy, and obtain a written acknowledgment of receipt from such applicant coincident with or prior to the execution of the application, the following information. The requirements of this section shall be deemed to have been satisfied to the extent that a disclosure containing information required by this section is delivered, either in the form of (1) a prospectus included in the requirements of the Securities Act of 1933 and which was declared effective by the Securities and Exchange Commission; or (2) all information and reports required by the Employee Retirement Income Security Act of 1974 if the policies are exempted from the registration requirements of the Securities Act of 1933 pursuant to Section 3(a)(2) thereof.

(1) A summary explanation, in non-technical terms, of the principal features of the policy, including a description of the manner in which the variable benefits will reflect the investment experience of the separate account and the factors which affect such variation. Such explanation must include notices of the provision required by 760 IAC 1-33-4(d)(1)(E) and (d)(6).

(2) A statement of the investment policy of the separate account, including:

(A) a description of the investment objectives intended for the separate account and the principal types of investments intended to be made; and

(B) any restriction or limitations on the manner in which the operations of the separate account are intended to be conducted.

(3) A statement of the net investment return of the separate account for each of the last ten (10) years or such lesser period as the separate account has been in existence.

(4) A statement of the charges levied against the separate account during the previous year.

(5) A summary of the method to be used in valuing assets held by the separate account.

(6) A summary of the federal income tax aspects of the policy applicable to the insured, the policyholder and the beneficiary.

(7) Illustrations of benefits payable under the variable life insurance contract. Such illustrations shall be prepared by the insurer and shall not include projections of past investment experience into the future or attempted predictions of future investment experience, provided that nothing contained herein prohibits use of hypothetical assumed rates of return to illustrate possible levels of benefits if it is made clear that such assumed rates are hypothetical only.

(Department of Insurance; 760 IAC 1-33-7; filed Mar 29, 1985, 1:46 pm: 8 IR 1023; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-33-8 Application for policy

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7

Sec. 8. The application for a variable life insurance policy shall contain:

(1) a prominent statement that the death benefit may be variable or fixed under specified conditions;

(2) a prominent statement that cash values may increase or decrease in accordance with the experience of the separate account (subject to any specified minimum guarantees);

(3) questions designed to elicit information which enables the insurer to determine the suitability of variable life insurance for the applicant.

(Department of Insurance; 760 IAC 1-33-8; filed Mar 29, 1985, 1:46 pm: 8 IR 1024; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-33-9 Reports to policyholders

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7

Sec. 9. Any insurer delivering or issuing for delivery in this state any variable life insurance policies shall mail to each variable life insurance policyholder at his or her last known address the following reports:

(1) Within thirty (30) days after each anniversary of the policy, a statement or statements of the cash surrender value, death benefit, any partial withdrawal or policy loan, any interest charge, any optional payments allowed pursuant to 760 IAC 1-33-4(e) under the policy computed as of the policy anniversary date. Provided, however, that such statement may be furnished within thirty (30) days after a specified date in each policy year so long as the information contained therein is computed as of a date not more than sixty (60) days prior to the mailing of such notice. This statement shall state that, in accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease, and shall prominently identify any value described therein which may be recomputed prior to the next statement required by this section. If the policy guarantees that the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in such statement, the statement shall be modified to so indicate. For flexible premium policies, the report must contain a reconciliation of the change since the previous report in cash value and cash surrender value, if different, because of payments made (less deductions for expense charges), withdrawals, investment experience, insurance charges and any other charges made against the cash value. In addition, the report must show the projected cash value and cash surrender value, if different, as of one (1) year from the end of the period covered by the report assuming that: (i) planned periodic premiums, if any, are paid as scheduled, (ii) guaranteed costs of insurance are deducted, and (iii) the net investment return is equal to the guaranteed rate or, in the absence of a guaranteed rate, is not greater than zero (0). If the projected value is less than zero (0), a warning message must be included that states that the policy may be in danger of terminating without value in the next twelve (12) months unless additional premium is paid.

(2) Annually, a statement or statements including:

(A) a summary of the financial statement of the separate account based on the annual statement last filed with the commissioner;

(B) the net investment return of the separate account for the last year and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of not less than five (5) years when available;

(C) a list of investments held by the separate account as of a date not earlier than the end of the last year for which an

annual statement was filed with the commissioner;

(D) any charges levied against the separate account during the previous year;

(E) a statement of any change, since the last report, in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account or in the investment adviser of the separate account.

(3) For flexible premium policies, a report must be sent to the policyholder if the amounts available under the policy on any policy processing day to pay the charges authorized by the policy are less than the amount necessary to keep the policy in force until the next following policy processing day. The report must indicate the minimum payment required under the terms of the policy to keep it in force and the length of the grace period for payment of such amount.

(Department of Insurance; 760 IAC 1-33-9; filed Mar 29, 1985, 1:46 pm: 8 IR 1024; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-33-10 Foreign companies; compliance with foreign law

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7

Sec. 10. If the law or regulation in the place of domicile of a foreign company provides a degree of protection to the policyholders and the public which is substantially similar to that provided by 760 IAC 1-33, the commissioner to the extent deemed appropriate by him in his discretion, may consider compliance with such law or regulation as compliance with 760 IAC 1-33. *(Department of Insurance; 760 IAC 1-33-10; filed Mar 29, 1985, 1:46 pm: 8 IR 1025; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-33-11 Sales agents; qualification (Repealed)

Sec. 11. *(Repealed by Department of Insurance; filed Jul 18, 1996, 9:00 a.m.: 19 IR 3466)*

760 IAC 1-33-12 Severability

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7

Sec. 12. If any provision of 760 IAC 1-33 or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of 760 IAC 1-33 and the application of such provision to other persons or circumstances shall not be affected thereby. *(Department of Insurance; 760 IAC 1-33-12; filed Mar 29, 1985, 1:46 pm: 8 IR 1026; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 34. Unfair Discrimination on the Basis of Blindness or Partial Blindness

760 IAC 1-34-1 Authority to promulgate rule

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7; IC 27-4-1-4; IC 27-4-1-8

Sec. 1. This rule *[760 IAC 1-34]* is adopted and promulgated pursuant to IC 27-1-3-7. *(Department of Insurance; 760 IAC 1-34-1; filed Oct 1, 1985, 4:01 pm: 9 IR 284; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-34-2 Purpose of rule

Authority: IC 27-1-3-7
Affected: IC 27-4-1-4; IC 27-4-1-8

Sec. 2. The purpose of this regulation *[760 IAC 1-34]* is to identify specific acts or practices, in addition to those defined in IC 27-4-1-4, which are prohibited as unfair or deceptive. *(Department of Insurance; 760 IAC 1-34-2; filed Oct 1, 1985, 4:01 pm:*

9 IR 284; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-34-3 Unfairly discriminatory acts or practices
Authority: IC 27-1-3-7
Affected: IC 27-4-1-4; IC 27-4-1-8

Sec. 3. The following are hereby identified as acts or practices which constitute unfair discrimination between individuals of the same class: Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging an individual a different rate for the same coverage, solely because of blindness or partial blindness. *(Department of Insurance; 760 IAC 1-34-3; filed Oct 1, 1985, 4:01 pm: 9 IR 284; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 35. New Annuity Mortality Tables

760 IAC 1-35-1 Authority to promulgate rule
Authority: IC 27-1-3-7
Affected: IC 27-1-3-7; IC 27-1-12-10

Sec. 1. This rule *[760 IAC 1-35]* is promulgated by the commissioner of insurance pursuant to IC 27-1-3-7. *(Department of Insurance; 760 IAC 1-35-1; filed Oct 16, 1985, 2:18 pm: 9 IR 517; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-35-2 Purpose of rule
Authority: IC 27-1-3-7
Affected: IC 27-1-12-10

Sec. 2. The purpose of this rule is to recognize the following mortality tables for use in determining the minimum standard of valuation for annuity and pure endowment contracts:
(1) the 1983 Table "a";
(2) the 1983 GAM Table;
(3) the Annuity 2000 Mortality Table; and
(4) the 1994 GAR Table.
(Department of Insurance; 760 IAC 1-35-2; filed Oct 16, 1985, 2:18 p.m.: 9 IR 517; filed Dec 1, 1999, 3:31 p.m.: 23 IR 810, eff Dec 31, 1999; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-35-3 Definitions
Authority: IC 27-1-3-7
Affected: IC 27-1-12-10

Sec. 3. The following definitions apply throughout this rule:
(1) "1983 Table "a"" means that mortality table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation and adopted as a recognized mortality table for annuities in June 1982 by the National Association of Insurance Commissioners.
(2) "1983 GAM Table" means that mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for annuities in December 1983 by the National Association of Insurance Commissioners.
(3) "1994 GAR Table" means that mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force and shown on pages 866 through 867 of Volume XLVII of the Transactions of the Society of Actuaries (1995).
(4) "Annuity 2000 Mortality Table" means that mortality table developed by the Society of Actuaries Committee on Life Insurance Research and shown on page 240 of Volume XLVII of the Transactions of the Society of Actuaries (1995).
(Department of Insurance; 760 IAC 1-35-3; filed Oct 16, 1985, 2:18 p.m.: 9 IR 517; filed Dec 1, 1999, 3:31 p.m.: 23 IR 810, eff Dec 31, 1999; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-35-4 Individual annuity or pure endowment contracts

Authority: IC 27-1-3-7
Affected: IC 27-1-12-10

Sec. 4. (a) Except as provided in subsections (b) and (c), the 1983 Table "a" is recognized and approved as an individual annuity mortality table for valuation and, at the option of the company, may be used for purposes of determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after August 31, 1979.

(b) Except as provided in subsection (c), either the 1983 Table "a" or the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1987.

(c) Except as provided in subsection (d), the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after December 31, 1999.

(d) The 1983 Table "a" without projection is to be used for determining the minimum standards of valuation for an individual annuity or pure endowment contract issued on or after December 31, 1999, solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from any of the following:

(1) Settlements of various forms of claims pertaining to court settlement or out of court settlement from tort actions.

(2) Settlements involving similar actions, such as worker's compensation claims.

(3) Settlement of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

(Department of Insurance; 760 IAC 1-35-4; filed Oct 16, 1985, 2:18 p.m.: 9 IR 517; filed Dec 1, 1999, 3:31 p.m.: 23 IR 810, eff Dec 31, 1999; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-35-5 Group annuity or pure endowment contracts

Authority: IC 27-1-3-7
Affected: IC 27-1-12-10

Sec. 5. (a) Except as provided in subsections (b) and (c), the 1983 GAM Table, the 1983 Table "a", and the 1994 GAR Table are recognized and approved as group annuity mortality tables for valuation and, at the option of the company, any one (1) of these tables may be used for purposes of valuation for an annuity or pure endowment purchased on or after August 31, 1979, under a group annuity or pure endowment contract.

(b) Except as provided in subsection (c), the 1983 GAM Table or the 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1987, under a group annuity or pure endowment contract.

(c) The 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after December 31, 1999, under a group annuity or pure endowment contract. *(Department of Insurance; 760 IAC 1-35-5; filed Oct 16, 1985, 2:18 p.m.: 9 IR 517; filed Dec 1, 1999, 3:31 p.m.: 23 IR 811, eff Dec 31, 1999; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-35-5.5 Application of the 1994 GAR table

Authority: IC 27-1-3-7
Affected: IC 27-1-12-10

Sec. 5.5. In using the 1994 GAR Table, the mortality rate for a person x years of age in year (1994 + n) is calculated as follows:

$$q_x^{1994+n} = q_x^{1994} (1 - AA_x)^n$$

where the q_x^{1994} and AA_xs are as specified in the 1994 GAR Table. *(Department of Insurance; 760 IAC 1-35-5.5; filed Dec 1, 1999, 3:31 p.m.: 23 IR 811, eff Dec 31, 1999; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-35-6 Severability of rule
Authority: IC 27-1-3-7
Affected: IC 27-1-12-10

Sec. 6. If any provision of this rule *[760 IAC 1-35]* or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby. *(Department of Insurance; 760 IAC 1-35-6; filed Oct 16, 1985, 2:18 pm: 9 IR 517; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 36. Smoker/Nonsmoker Mortality Tables

760 IAC 1-36-1 Authority to promulgate rule
Authority: IC 27-1-3-7
Affected: IC 27-1-12-7; IC 27-1-12-10

Sec. 1. This rule *[760 IAC 1-36]* is promulgated pursuant to IC 27-1-3-7. *(Department of Insurance; 760 IAC 1-36-1; filed Oct 16, 1985, 2:18 pm: 9 IR 517; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-36-2 Purpose of rule
Authority: IC 27-1-3-7
Affected: IC 27-1-12-7; IC 27-1-12-10

Sec. 2. The purpose of this rule *[760 IAC 1-36]* is to permit the use of mortality tables that reflect differences in mortality between smokers and nonsmokers in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits for plans of insurance with separate premium rates for smokers and nonsmokers. *(Department of Insurance; 760 IAC 1-36-2; filed Oct 16, 1985, 2:18 pm: 9 IR 517; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-36-3 Definitions
Authority: IC 27-1-3-7
Affected: IC 27-1-12-7; IC 27-1-12-10

Sec. 3. (a) As used in this rule *[760 IAC 1-36]*, "1980 CSO Table, with or without Ten-Year Select Mortality Factor" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Standard Ordinary Mortality Table, with or without Ten-Year Select Mortality Factors. The same select factors will be used for both smokers and nonsmokers tables.

(b) As used in this rule *[760 IAC 1-36]*, "1980 CET Table" means that mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Extended Term Insurance Table.

(c) As used in this rule *[760 IAC 1-36]*, "1958 CSO Table" means that mortality table developed by the Society of Actuaries Special Committee on New Mortality Tables, incorporated in the NAIC Model Standard Nonforfeiture Law for Life Insurance, and referred to in that model as the Commissioners 1958 Standard Ordinary Mortality Table.

(d) As used in this rule *[760 IAC 1-36]*, "1958 CET Table" means that mortality table developed by the Society of Actuaries Special Committee on New Mortality Tables, incorporated in the NAIC Model Standard Nonforfeiture Law for Life Insurance, and referred to in that model as the Commissioners 1958 Extended Term Insurance Table.

(e) As used in this rule *[760 IAC 1-36]*, the phrase "smoker and nonsmoker mortality tables" refers to the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the tables defined in subsections (a) through (d) of this section which were developed by the Society of Actuaries Task Force on Smoker/Nonsmoker Mortality and the California Insurance

Department staff and recommended by the NAIC Technical Staff Actuarial Group.

(f) As used in this rule *[760 IAC 1-36]*, the phrase "composite mortality tables" refers to the mortality tables defined in subsections (a) through (d) of this section as they were originally published with rates of mortality that do not distinguish between smokers and nonsmokers.

(g) As used in this rule *[760 IAC 1-36]*, the phrase "operative date" for a policy form means that date, after the election date described below, on which the form is filed with this department.

NOTE: A company elects to use 1980 CSO Mortality Tables in Indiana by filing an election letter with the department, said letter including an election date and providing that all company filings of any policy forms submitted after the election date shall utilize 1980 CSO Tables.

(Department of Insurance; 760 IAC 1-36-3; filed Oct 16, 1985, 2:18 pm: 9 IR 518; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-36-4 Applicable tables

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7; IC 27-1-12-10

Sec. 4. (a) For any policy of insurance delivered or issued for delivery in this state after the operative date for that policy form which occurs after the effective date of this rule *[760 IAC 1-36]* and before January 1, 1989, at the option of the company and subject to the conditions stated in section 5 of this rule *[760 IAC 1-36-5]*,

(1) the 1958 CSO Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors, and

(2) the 1958 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table

for use in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

Provided that for any category of insurance issued on female lives with minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits determined using the 1958 CSO or 1958 CET Smoker and Nonsmoker Mortality Tables, such minimum values may be calculated according to an age not more than six years younger than the actual age of the insured.

Provided further that the substitution of the 1958 CSO or 1958 CET Smoker and Nonsmoker Mortality Tables is available only if made for each policy of insurance on a policy form delivered or issued for delivery on or after the operative date for that policy form which occurs after the effective date of this rule *[760 IAC 1-36]* and before a date not later than January 1, 1989.

(b) For any policy of insurance delivered or issued for delivery in this state after the operative date for that policy form which occurs after the effective date of this rule *[760 IAC 1-36]*, at the option of the company and subject to the conditions stated in section 5 of this rule *[760 IAC 1-36-5]*,

(1) the 1980 CSO Smoker and Nonsmoker Mortality Tables, with or without Ten-Year Select Mortality Factors, may be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors, and

(2) the 1980 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table

for use in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

(c) The options specified in subsection (a) of this rule *[this section]* shall not be available to a company on or after the effective date of that company's election to use 1980 CSO Mortality Tables for all its future filings in this state. *(Department of Insurance; 760 IAC 1-36-4; filed Oct 16, 1985, 2:18 pm: 9 IR 518; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-36-5 Use of tables

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7; IC 27-1-12-10

Sec. 5. For each plan of insurance with separate rates for smokers and nonsmokers an insurer may:

(1) use composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits,

(2) use smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by IC 27-1-12-10(6) and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits, or

(3) use smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

(Department of Insurance; 760 IAC 1-36-5; filed Oct 16, 1985, 2:18 pm: 9 IR 519; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-36-6 Severability of rule

Authority: IC 27-1-3-7
Affected: IC 27-1-12-7; IC 27-1-12-10

Sec. 6. If any provision of this rule *[760 IAC 1-36]* or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby. *(Department of Insurance; 760 IAC 1-36-6; filed Oct 16, 1985, 2:18 pm: 9 IR 519; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 37. Political Subdivision Risk Management Fund

760 IAC 1-37-1 Authority

Authority: IC 27-1-29-16
Affected: IC 27-1-29

Sec. 1. 760 IAC 1-37 is promulgated under the authority of IC 27-1-19-16 *[sic., IC 27-1-29-16]* of the insurance laws of Indiana and is effective upon promulgation. *(Department of Insurance; 760 IAC 1-37-1; filed Sep 30, 1986, 3:01 pm: 10 IR 252; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-37-2 Definitions

Authority: IC 27-1-29-16
Affected: IC 27-1-29-1; IC 27-1-29-2

Sec. 2. As used in this regulation:

(1) "Commission" refers to the Indiana political subdivision risk management commission established by IC 27-1-29-1.

(2) "Fund" refers to the political subdivision risk management fund established by IC 27-1-29-2. *(Department of Insurance; 760 IAC 1-37-2; filed Sep 30, 1986, 3:01 pm: 10 IR 252; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-37-3 Capitalization requirement

Authority: IC 27-1-29-16
Affected: IC 27-1-29-7

Sec. 3. The minimum capitalization for the fund shall initially be set at $1,250,000. The commission shall change the capitalization requirement as needed. All members of the fund will be surcharged annually, as needed, on January 1 of each year to meet the capitalization required, subject to the limitation found in IC 27-1-29-7(a). After the first year of operation annual surcharges will include adjustments for membership changes and prior year contributions. *(Department of Insurance; 760 IAC 1-37-3; filed Sep 30, 1986, 3:01 pm: 10 IR 252; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-37-4 Capital contribution as an investment

Authority: IC 27-1-29-16
Affected: IC 27-1-29-7

Sec. 4. Capital contributions will be treated as a noninterest bearing investment in the fund. The commission shall establish procedures for the return of such investments; said return to occur no later than the date of dissolution of the fund. *(Department of Insurance; 760 IAC 1-37-4; filed Sep 30, 1986, 3:01 pm: 10 IR 252; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-37-5 Claims payment agreement

Authority: IC 27-1-29-16
Affected: IC 27-1-29-14; IC 27-1-29-15

Sec. 5. The particular claims that will be eligible for payment from the fund will consist of liabilities for:

(1) bodily injury and property damage evolving from:
- (A) government premises;
- (B) operations of government;
- (C) contractual liability;
- (D) products liability;
- (E) completed operations liability;

(2) personal injury arising from:
- (A) false arrest;
- (B) false imprisonment;
- (C) malicious prosecution;
- (D) libel;
- (E) slander;
- (F) invasion of the right of private occupancy;
- (G) violation of civil and constitutional rights;
- (H) assault;
- (I) battery;
- (J) police, sheriff's, and other professional liability;
- (K) errors and omissions liability;

as defined in the claims payment agreement. The term of the claims payment agreement will be a calendar year with an effective date of January 1 and an expiration date of December 31. Any member joining the fund during a calendar year will receive an agreement that will be effective only until December 31 of that year. If membership in the fund starts after January 1 of any year, assessments and surcharges for that year will be based on partial year participation in the fund. Renewal agreements will then cover a calendar year as previously described. *(Department of Insurance; 760 IAC 1-37-5; filed Sep 30, 1986, 3:01 pm: 10 IR 253; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-37-6 Admission requirements

Authority: IC 27-1-29-16
Affected: IC 27-1-29-15

Sec. 6. The conditions for membership will be specified on the application forms supplied by the commission. Upon successful completion and submission of an application an applicant will be notified of the applicable assessment and surcharge. The issuance of the claims payment agreement and return of the members acceptance form shall constitute proof of membership in the fund. *(Department of Insurance; 760 IAC 1-37-6; filed Sep 30, 1986, 3:01 pm: 10 IR 253; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-37-7 Termination of membership

Authority: IC 27-1-29-16
Affected: IC 27-1-29-15

Sec. 7. Any member wishing to withdraw from the fund shall file written notice of such intent by certified mail or in person with the commissioner of insurance. The effective date of the notice shall be the date the notice is received by the commissioner

of insurance. Termination of membership shall be effective one year from the date of the above filed notice unless an earlier termination date is specified by the commission, but in no event shall termination occur less than 60 days after the filing of such notice unless mutually agreed to by the commission and fund member. At any time prior to the termination date of membership a member may rescind its intent to withdraw from the fund by written notice to the commissioner of insurance. If a member withdraws from the fund, there shall be no return of any assessment paid prior to the date of membership termination. *(Department of Insurance; 760 IAC 1-37-7; filed Sep 30, 1986, 3:01 pm: 10 IR 253; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-37-8 Risk management program

Authority: IC 27-1-29-16
Affected: IC 27-1-29-7

Sec. 8. During membership, each member shall be required to participate in a risk management program as defined by the commission. *(Department of Insurance; 760 IAC 1-37-8; filed Sep 30, 1986, 3:01 pm: 10 IR 253; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-37-9 Eligibility of claim

Authority: IC 27-1-29-16
Affected: IC 27-1-29-14

Sec. 9. The commission shall determine whether a claim is eligible for payment from the fund. *(Department of Insurance; 760 IAC 1-37-9; filed Sep 30, 1986, 3:01 pm: 10 IR 253; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-37-10 Claim settlement procedure

Authority: IC 27-1-29-16
Affected: IC 27-1-29-14

Sec. 10. All claim settlements, whether within the deductible provision or not of the claims paying agreement, must include a release statement approved by the commission. *(Department of Insurance; 760 IAC 1-37-10; filed Sep 30, 1986, 3:01 pm: 10 IR 253; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-37-11 Agent commissions

Authority: IC 27-1-29-16
Affected: IC 27-1-29-7

Sec. 11. All applicants to the fund will apply through a licensed agent and the licensed agent will be paid 7.5 percent of all assessments paid by any member procured by that agent. The agent's commission will not apply to the capitalization of the fund. *(Department of Insurance; 760 IAC 1-37-11; filed Apr 8, 1987, 3:30 pm: 10 IR 1700; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-37-12 Deductibles

Authority: IC 27-1-29-16
Affected: IC 27-1-29-7

Sec. 12. At the discretion of the commission, a deductable *[sic.]* and/or deductables *[sic.]* of $1000, $5000, or $10,000 will be offered to each member. *(Department of Insurance; 760 IAC 1-37-12; filed Apr 8, 1987, 3:30 pm: 10 IR 1700; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 38. Group Coordination of Benefits (Repealed)

(Repealed by Department of Insurance; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1175)

Rule 38.1. Group Coordination of Benefits

760 IAC 1-38.1-1 Purpose; applicability

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 1. The purpose of this rule is to:
(1) permit, but not require, plans to include a coordination of benefits provision;
(2) establish an order in which plans pay their claims;
(3) provide the authority for the orderly transfer of information needed to pay claims promptly;
(4) reduce duplication of benefits by permitting a reduction of the benefits paid by a plan when the plan, pursuant to these rules, does not have to pay its benefits first;
(5) reduce claims payment delays; and
(6) make all contracts that contain a coordination of benefits provision consistent with this rule.

(Department of Insurance; 760 IAC 1-38.1-1; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1169; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-38.1-2 "Allowable expenses" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 2. (a) As used in this rule, "allowable expenses" means the necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

(b) Notwithstanding subsection (a), items of expense under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of allowable expense. A plan which provides benefits only for any such items of expense may limit its definition of allowable expenses to like items of expense.

(c) When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

(d) The difference between the cost of a private hospital room and the cost of a semiprivate room is not considered an allowable expense under subsection (a), unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

(e) When coordination of benefits is restricted in its use to specific coverage in a contract, for example, major medical or dental, the definition of "allowable expense" must include the corresponding expenses or services to which coordination of benefits applies.

(f) When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(g) Only benefit reductions based upon provisions similar in purpose to those described in subsection (f) and which are contained in the primary plan may be excluded from allowable expenses. The provisions of subsection (f) shall not be used by a secondary plan to refuse to pay benefits because a health maintenance organization (HMO) member has elected to have health care services provided by a nonHMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services.

(Department of Insurance; 760 IAC 1-38.1-2; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1169; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-38.1-3 "Claim" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 3. As used in this rule, "claim" means a request that benefits of a plan be provided or paid. A claim may be for:

(1) services (including supplies);
(2) payment for all or a portion of the expenses incurred;
(3) a combination of subdivisions (1) through (2); or
(4) an indemnification.

(Department of Insurance; 760 IAC 1-38.1-3; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1170; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-38.1-4 "Claim determination period" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 4. (a) As used in this rule, "claim determination period" means the period of time, which must not be less than twelve (12) consecutive months, over which allowable expenses are compared with total benefits payable in the absence of coordination of benefits, to determine whether overinsurance exists and how much each plan will pay or provide.

(b) The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

(c) As each claim is submitted, each plan is to determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period. *(Department of Insurance; 760 IAC 1-38.1-4; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1170; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-38.1-5 "Coordination of benefits" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 5. As used in this rule, "coordination of benefits" means a provision establishing an order in which plans pay their claims. *(Department of Insurance; 760 IAC 1-38.1-5; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1170; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-38.1-6 "Hospital indemnity benefits" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 6. As used in this rule, "hospital indemnity benefits" means benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim. *(Department of Insurance; 760 IAC 1-38.1-6; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1170; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-38.1-7 "Plan" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 7. (a) As used in this rule, "plan" means a form of coverage with which coordination is allowed. The definition of plan in the group contract must state the types of coverage which will be considered in applying the coordination of benefits provision of that contract. The right to include a type of coverage is limited by subsections (b) through (d).

(b) This rule uses the term "plan". However, a group contract may, instead, use "program" or some other term.

(c) A plan may include the following:
(1) Group insurance and group subscriber contracts.
(2) Uninsured arrangements of group or group-type coverage.

(3) Group or group-type coverage through health maintenance organizations (HMOs) and other prepayment, group practice, and individual practice plans.

(4) Group-type contracts which are contracts not available to the general public and which can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition of plan, at the option of the insurer or the service provider and the contract client whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated, for example, "franchise" or "blanket". Individually underwritten and issued guaranteed renewable policies would not be considered "group-type" even though purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

(5) The amount by which group or group-type hospital indemnity benefits exceed one hundred dollars ($100) per day.

(6) The medical benefits coverage in group, group-type, and individual automobile "no fault" and traditional automobile "fault" type contracts.

(7) Medicare or other governmental benefits, except as provided in subsection (d)(7). That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

(d) A plan shall not include the following:

(1) Individual or family insurance contracts.

(2) Individual or family subscriber contracts.

(3) Individual or family coverage through health maintenance organizations.

(4) Individual or family coverage under other prepayment, group practice, and individual practice plans.

(5) Group or group-type hospital indemnity benefits of one hundred dollars ($100) per day or less.

(6) School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour basis or on a "to and from school" basis.

(7) A state plan under Medicaid, and shall not include a law or plan when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.

(Department of Insurance; 760 IAC 1-38.1-7; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1170; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-38.1-8 "Primary plan" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 8. As used in this rule, "primary plan" means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either of the following conditions are true:

(1) The plan either has no order of benefit determination rules, or it has rules which differ from those permitted by this rule. There may be more than one (1) primary plan.

(2) All plans which cover the person use the order of benefit determination provisions of this rule, and under this rule the plan determines its benefits first.

(Department of Insurance; 760 IAC 1-38.1-8; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1171; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-38.1-9 "Secondary plan" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 9. As used in this rule, "secondary plan" means a plan which is not a primary plan. If a person is covered by more than one (1) secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of the primary plan or plans and the benefits of any other plan which, under these rules, has its benefits determined before those of that secondary plan. *(Department*

of Insurance; 760 IAC 1-38.1-9; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1171; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-38.1-10 "This plan" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 10. "This plan", in a coordination of benefits provision, refers to the part of the group contract providing the health care benefits to which the coordination of benefits provision applies and which may be reduced because of the benefits of other plans. Any other part of the group contract providing health care benefits is separate from this plan. A group contract may apply one (1) coordination of benefits provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate coordination of benefits provisions to coordinate other benefits. *(Department of Insurance; 760 IAC 1-38.1-10; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1171; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-38.1-11 Model coordination of benefits provision; prohibited coordination; benefit design

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 11. (a) A model coordination of benefits provision for use in group contracts, contained as Appendix A to the Group Coordination of Benefits Model Regulation as adopted and amended in December, 1988, by the National Association of Insurance Commissioners (NAIC) (1989 Proc. I), appearing in the NAIC Model Insurance Laws, Regulations and Guidelines, Vol. I, pages 120-9 through 120-13, is hereby adopted by reference, as if fully set out in this rule.

(b) A group contract's coordination of benefits provision does not have to use the words and format shown in the model provision adopted by reference in subsection (a). Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among plans which provide services, which pay benefits for expenses incurred, and which indemnify. No other substantive changes are allowed.

(c) A group contract may not reduce benefits on the basis that:

(1) another plan exists;

(2) a person is or could have been covered under another plan, except with respect to Part B of Medicare; or

(3) a person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.

(d) No contract may contain a provision that its benefits are "excess" or "always secondary" to any plan as defined in section 7 of this rule, except in compliance with these rules. *(Department of Insurance; 760 IAC 1-38.1-11; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1172; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-38.1-12 Order of benefits; general

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 12. (a) The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist. A plan that does not include a coordination of benefits provision may not take the benefits of another plan as defined in section 7 of this rule into account when it determines its benefits. One (1) exception is that a contract holder's coverage which is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.

(b) A secondary plan may take the benefits of another plan into account only when, under this rule, it is secondary to that other plan.

(c) The benefits of the plan which covers the person as an employee, member, or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent. *(Department of Insurance; 760 IAC 1-38.1-12; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1172; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-38.1-13 Order of benefits for dependent child/parents not separated or divorced

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 13. (a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year.

(b) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

(c) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.

(d) A group contract which includes coordination of benefits and which is issued or renewed, or which has an anniversary date on or after sixty (60) days after the effective date of this rule shall include the substance of the provision in subsections (a) through (c). Until that provision becomes effective, the group contract may instead contain wording such as: "Except as stated in 760 IAC 1-38.1-14, the benefits of a plan which covers a person as a dependent of a male are determined before those of a plan which covers the person as a dependent of a female.".

(e) If the other plan does not have the provisions described in subsections (a) through (c), but instead has a provision based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the provision based upon the gender of the parent will determine the order of benefits. *(Department of Insurance; 760 IAC 1-38.1-13; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1172; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-38.1-14 Order of benefits for dependent child/separated or divorced parents

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 14. (a) If two (2) or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in the following order:

(1) The plan of the parent with custody of the child.

(2) The plan of the spouse of the parent with custody of the child.

(3) The plan of the parent not having custody of the child.

(b) If the specific terms of a court decree state that one (1) of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This subsection does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(c) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outline set forth in section 13 of this rule. *(Department of Insurance; 760 IAC 1-38.1-14; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1173; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-38.1-15 Order of benefits for active/inactive employee

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 15. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this provision, and if, as a result, the plans do not agree on the order of benefits, this section is ignored. *(Department of Insurance; 760 IAC 1-38.1-15; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1173; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-38.1-16 Order of benefits for longer/shorter length of coverage

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 16. (a) If the provisions of sections 12 through 15 of this rule do not determine the order of benefits, the benefits of the plan which covered an employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter term.

(b) To determine the length of time a person has been covered under a plan, two (2) plans shall be treated as one (1) if the claimant was eligible under the second within twenty-four (24) hours after the first ended.

(c) The start of a new plan does not include:

(1) a change in the amount or scope of a plan's benefits;

(2) a change in the entity which pays, provides, or administers the plan's benefits; or

(3) a change from one (1) type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(d) The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under the plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force. *(Department of Insurance; 760 IAC 1-38.1-16; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1173; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-38.1-17 Secondary plan procedures; total allowable expenses

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 17. (a) When it is determined under sections 12 through 16 of this rule that this plan is a secondary plan, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than total allowable expenses. The amount by which the secondary plan's benefits have been reduced shall be used by the secondary plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, the secondary plan determines its obligation to pay for allowable expenses based on all claims which were submitted up to that point in time during the claim determination period.

(b) The benefits of the secondary plan will be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of the coordination of benefits provision and the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of the secondary plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

(c) When the benefits of this plan are reduced as described in subsection (b), each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

(d) Subsection (c) may be omitted if the plan provides only one (1) benefit, or may be altered to suit the coverage provided. *(Department of Insurance; 760 IAC 1-38.1-17; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1173; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-38.1-18 Reasonable cash values of services

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 18. A secondary plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this section shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan which provides benefits in the form of services. *(Department of Insurance; 760 IAC 1-38.1-18; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1174; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-38.1-19 Excess and other nonconforming provisions

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 19. (a) Some plans have order of benefit determination provisions not consistent with this rule, which declare that the plan's coverage is "excess" to all others, or "always secondary". This occurs because certain plans may not be subject to insurance regulation, or because some group contracts have not yet conformed with this rule.

(b) A plan with order of benefit determination provisions which comply with this rule (complying plan), may coordinate its benefits with a plan which is "excess" or "always secondary", or which uses order of benefit determination provisions which are inconsistent with those contained in this rule (noncomplying plan), on the following basis:

(1) If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis.

(2) If the complying plan is the secondary plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, such payment shall be the limit of the complying plan's liability.

(3) If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. However, the complying plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the noncomplying plan.

(c) If the noncomplying plan reduces its benefits so that the employee, subscriber, or member receives less in benefits than he or she would have received had the complying plan paid or provided its benefits as the secondary plan, and the noncomplying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation under section 21 of this rule, then the complying plan shall advance to or on behalf of the employee, subscriber, or member an amount equal to such difference.

(d) In no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid. In consideration of such advance, the complying plan shall be subrogated to all rights of the employee, subscriber, or member against the noncomplying plan. Such advance by the complying plan shall also be without prejudice to any claim it may have against the noncomplying plan in the absence of such subrogation. *(Department of Insurance; 760 IAC 1-38.1-19; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1174; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-38.1-20 Allowable expense

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 20. A term such as "usual and customary", "usual and prevailing", or "reasonable and customary" may be substituted for the term "necessary, reasonable, and customary". Terms such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the coordination of benefits provisions apply. *(Department of Insurance; 760 IAC 1-38.1-20; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1174; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-38.1-21 Subrogation

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 21. The coordination of benefits concept clearly differs from that of subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other. *(Department of Insurance; 760 IAC 1-38.1-21; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1175; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-38.1-22 Effectiveness

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 22. A group contract which provides health care benefits and was issued before the effective date of this rule shall be brought into compliance with this rule by the later of:

(1) the next anniversary date or renewal date of the group contract; or

(2) the expiration of any applicable collectively bargained contract pursuant to which it was written.

(Department of Insurance; 760 IAC 1-38.1-22; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1175; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 39. AIDS Questioning, Testing and Coverage

760 IAC 1-39-1 Authority

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7; IC 27-1-3-19; IC 27-1-12-13; IC 27-8-5-1

Sec. 1. This rule (760 IAC 1-39) is promulgated by the insurance commissioner of the department of insurance of the state of Indiana pursuant to IC 27-1-3-7 of the Indiana insurance law. *(Department of Insurance; 760 IAC 1-39-1; filed May 13, 1988, 10:30 am: 11 IR 3557; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-39-2 Purpose (Repealed)

Sec. 2. *(Repealed by Department of Insurance; filed Nov 5, 1999, 10:17 a.m.: 23 IR 572)*

760 IAC 1-39-3 Definitions

Authority: IC 27-1-3-7
Affected: IC 27-1-3-19; IC 27-1-12-13; IC 27-8-5-1

Sec. 3. The following definitions apply throughout this rule:

(1) "AIDS" means acquired immune deficiency syndrome.

(2) "Commissioner" means the commissioner of the Indiana department of insurance.

(3) "HIV" means human immunodeficiency virus.

(Department of Insurance; 760 IAC 1-39-3; filed May 13, 1988, 10:30 a.m.: 11 IR 3557; filed Nov 5, 1999, 10:17 a.m.: 23 IR 570; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-39-4 Application questions

Authority: IC 27-1-3-7
Affected: IC 27-1-3-19; IC 27-1-12-13; IC 27-8-5-1

Sec. 4. In its applications for coverage, an insurer may ask any questions of a medically specific nature that are necessary to render a fully informed underwriting determination based upon sound actuarial principles concerning whether to accept or rate a particular risk, subject to the following conditions:

(1) No question in an application for health or life insurance coverage shall be directed towards determining the applicant's sexual orientation.

(2) No question shall be used which is designed to establish the sexual orientation of the applicant.

(3) Questions relating to the applicant having:

(A) HIV; or

(B) been diagnosed as having HIV;

are permissible if they are factual, objective, and designed to establish the existence of the condition.

(4) Questions relating to medical and other factual matters intending to reveal the possible existence of medical conditions are permissible if they are not used as a proxy to establish the sexual orientation of the applicant, and the applicant has been given an opportunity to provide an explanation for any affirmative answers given in the application. Questions shall be related to a finite period of time preceding completion of the application, shall be specific, objective, and shall provide the applicant

the opportunity to give a detailed explanation.

(5) Questions relating to the applicant having:

(A) a sexually transmitted disease;

(B) been diagnosed as having a sexually transmitted disease; or

(C) been advised to seek treatment for a sexually transmitted disease;

are permissible.

(Department of Insurance; 760 IAC 1-39-4; filed May 13, 1988, 10:30 a.m.: 11 IR 3557; filed Nov 5, 1999, 10:17 a.m.: 23 IR 571; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-39-5 Testing requirements and protocol

Authority: IC 27-1-3-7

Affected: IC 27-1-3-19; IC 27-1-12-13; IC 27-8-5-1

Sec. 5. An insurer may require a potential insured to submit to any medical tests, at the insurer's expense, the purpose of which is to determine infection with HIV, subject to the following conditions:

(1) The test is necessary to render a fully informed underwriting determination based upon sound actuarial principles concerning whether to accept or rate a particular risk.

(2) Whenever an applicant is requested to take a test to determine HIV infection in connection with an application for insurance, the use of such a test must be revealed to the applicant and his or her written consent obtained. No adverse underwriting decision shall be made on the basis of such a positive test unless an established test protocol has been followed.

(3) The following test protocol is established and must be the basis of an adverse underwriting determination:

(A) Two (2) positive ELISA tests.

(B) One (1) Western Blot test, which is not negative, must be obtained from the same sample b from tests conducted by a qualified laboratory.

Notwithstanding, the commissioner may approve an alternative screening and confirmatory test protocol that utilizes a screening and confirmatory test approved by the federal Food and Drug Administration for detecting the presence of HIV or HIV antibodies that is no less accurate than ELISA and Western Blot protocol.

(4) All results of tests to determine HIV infection and application responses are confidential and shall not be shared with anyone other than the applicant, the applicant's physician, and the insurer's underwriting department, except as follows:

(A) Test results and application responses may be shared with underwriting departments of affiliates of the insurer and reinsurers, who shall be subject to all provisions of this rule as if they were the insurer to which application was originally made.

(B) Test results may be reported to the Medical Information Bureau, Inc., provided that:

(i) the insurer will not report that tests of an applicant showed the presence of HIV, but only that unspecified test results were abnormal; and

(ii) reports must use a general code that also covers results of tests for many diseases or conditions that are not related to HIV or AIDS.

(Department of Insurance; 760 IAC 1-39-5; filed May 13, 1988, 10:30 a.m.: 11 IR 3557; filed Nov 5, 1999, 10:17 a.m.: 23 IR 571; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-39-6 Underwriting and rating determinations

Authority: IC 27-1-3-7

Affected: IC 27-1-3-19; IC 27-1-12-13; IC 27-8-5-1

Sec. 6. An insurer may make an underwriting or a rating determination based upon questions asked pursuant to section 4 of this rule and upon tests required pursuant to section 5 of this rule, subject to the following conditions:

(1) Sexual orientation may not be used in the underwriting process or in the determination of insurability.

(2) Insurance support organizations shall be directed by insurers not to investigate, directly or indirectly, the sexual orientation of an applicant or a beneficiary.

(3) Neither the marital status, the living arrangements, the occupation, the gender, the medical history, the beneficiary

designation, nor the zip code or other territorial classification of an applicant may be used to establish, or aid in establishing, the applicant's sexual orientation.

(4) For purposes of rating an applicant for health and life insurance, an insurer may impose territorial rates, but only if the rates are based on sound actuarial principles or are related to actual or reasonably anticipated experience.

(5) No adverse underwriting decision shall be made because medical records or a report from an insurance support organization shows that the applicant has demonstrated concern about HIV by seeking testing or counseling from health care professionals. This subsection does not apply to an applicant seeking treatment or diagnosis for a specific condition.

(Department of Insurance; 760 IAC 1-39-6; filed May 13, 1988, 10:30 a.m.: 11 IR 3558; filed Nov 5, 1999, 10:17 a.m.: 23 IR 572; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-39-7 Limitations and exclusions prohibited

Authority: IC 27-1-3-7
Affected: IC 27-1-3-19; IC 27-1-12-13; IC 27-8-5-1

Sec. 7. In the event an insurer determines to accept a risk, it must do so without limitations or exclusions solely of the coverage for HIV, AIDS, or a related condition, as follows:

(1) No maximum dollar amount of coverage, which is limited solely to HIV, AIDS, or a related condition, shall be included in any policy or certificate.

(2) No exclusion of coverage, which is limited solely to HIV, AIDS, or a related condition, shall be included in any policy or certificate.

This section shall not apply to those policies that provide coverage only for specified diseases. *(Department of Insurance; 760 IAC 1-39-7; filed May 13, 1988, 10:30 a.m.: 11 IR 3558; filed Nov 5, 1999, 10:17 a.m.: 23 IR 572; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-39-8 Departmental approval of policy

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7; IC 27-1-3-19; IC 27-1-12-13; IC 27-8-5-1

Sec. 8. No group or individual life or health insurance policy which is not in compliance with 760 IAC 1-39 will be approved by the department of insurance of the state of Indiana for issue in this state on or after the effective date of 760 IAC 1-39. As of the effective date of 760 IAC 1-39, approval is withdrawn from all group and individual life and health insurance policies approved prior to the effective date which do not meet the requirements set forth in 760 IAC 1-39. *(Department of Insurance; 760 IAC 1-39-8; filed May 13, 1988, 10:30 am: 11 IR 3558; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-39-9 Separability

Authority: IC 27-1-3-7
Affected: IC 27-1-3-7; IC 27-1-3-19; IC 27-1-12-13; IC 27-8-5-1

Sec. 9. If any provisions of this rule *[760 IAC 1-39]* or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby. *(Department of Insurance; 760 IAC 1-39-9; filed May 13, 1988, 10:30 am: 11 IR 3559; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 40. Agent Prelicensing Study Program

760 IAC 1-40-1 Authority

Authority: IC 27-1-3-7
Affected: IC 27-1-15.5-4; IC 27-1-15.5-19

Sec. 1. The following rule *[760 IAC 1-40]* applicable to pre-licensing education requirements is promulgated under the

authority of IC 27-1-15.5-4 and IC 27-1-15.5-19. *(Department of Insurance; 760 IAC 1-40-1; filed Jan 7, 1988, 1:43 pm: 11 IR 1588; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-40-2 Purpose

Authority: IC 27-1-3-7
Affected: IC 27-1-15.5

Sec. 2. The purpose of this rule *[760 IAC 1-40]* is to prescribe a course of study to be completed by each applicant prior to taking the written licensing examination; to establish the requirements for certification of an individual who seeks to be qualified as an instructor or director of a registered insurance agent program of study; and to adopt the reasonable and necessary forms to carry out the stated purposes of this rule *[760 IAC 1-40]* and those set forth in IC 27-1-15.5. *(Department of Insurance; 760 IAC 1-40-2; filed Jan 7, 1988, 1:43 pm: 11 IR 1588; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-40-3 Definitions

Authority: IC 27-1-3-7
Affected: IC 27-1-15.5

Sec. 3. As used in this rule or any form adopted pursuant to this rule:

(a) "Approved instructor" means a person who has met the qualifications as prescribed in 760 IAC 1-40-5 *[section 5 of this rule]*.

(b) A registered insurance agent program means a course of studies which:

(1) is taught by an approved instructor;

(2) presents all course materials as designated in the pertinent section of 760 IAC 1-40-6 *[section 6 of this rule]*; and

(3) has been approved by the commissioner.

(c) "Structured setting" is one which meets at a set time and at a fixed location. *(Department of Insurance; 760 IAC 1-40-3; filed Jan 7, 1988, 1:43 p.m.: 11 IR 1588; filed Aug 15, 1988, 4:00 p.m.: 12 IR 25; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-40-3.1 Renewal of commissioner approval for a registered program

Authority: IC 27-1-3-7
Affected: IC 27-1-15.5

Sec. 3.1. (a) The commissioner's approval for a registered agent program is valid for three (3) years from the date of approval of the agent program's most recent registration application.

(b) In order to renew the commissioner's approval for a registered agent program, the qualified program director shall submit no later than sixty (60) days prior to the expiration of the agent program's valid approval, the following:

(1) An application to renew the commissioner's approval.

(2) A renewal fee.

(3) If the program material has been modified, altered, or changed from the program material indicated and approved at the time of the registered agent program's most recent registration application, the modified, altered, or changed material must be submitted with the application for review. If the program material is the same as that which was approved at the time of the registered agent program's most recent registration application, the renewal application shall identify the program material and indicate that it is the same that has been previously approved.

(c) If a registered agent program seeks to modify, alter, or change the program material indicated and approved at the time of the registered agent program's most recent registration application, the qualified program director shall submit the following:

(1) An application for modification, alteration, or change of program material.

(2) A fee for modification, alteration, or change.

(Department of Insurance; 760 IAC 1-40-3.1; filed Aug 4, 1992, 5:00 p.m.: 15 IR 2589; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-40-4 Qualifications for program director

Authority: IC 27-1-3-7
Affected: IC 27-1-15.5

Sec. 4. (a) To qualify as a program director an individual must meet the following criteria:

(1) hold a high school diploma; and

(2) acquired the following experience:

(A) two or more years of experience as an instructor of insurance or an educational administrator; or

(B) six or more years of experience in the insurance industry with two years in insurance management; or

(C) earned the designation of CLU, CPCU, FLMI, CIC or CHFC.

(b) No person may qualify as a program director who:

(1) has been convicted of a crime involving moral turpitude; or

(2) has had his/her insurance agent's license suspended or revoked in Indiana or in any other state; or

(3) has outstanding any fines imposed by the commissioner for insurance related disciplinary offenses; or

(4) is on the most recent tax warrant list supplied to the commissioner by the department of state revenue.

(Department of Insurance; 760 IAC 1-40-4; filed Jan 7, 1988, 1:43 pm: 11 IR 1588; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-40-4.1 Renewal for program director

Authority: IC 27-1-3-7
Affected: IC 27-1-15.5

Sec. 4.1. (a) Qualification of a program director is valid for three (3) years from the date of the commissioner's approval of the program director's most recent application to qualify as a program director.

(b) A qualified program director who desires to renew qualification to be a program director shall submit to the commissioner no later than sixty (60) days prior to the expiration of the program director's qualification, the following:

(1) An application for renewal of approval as a program director.

(2) A renewal fee.

(Department of Insurance; 760 IAC 1-40-4.1; filed Aug 4, 1992, 5:00 p.m.: 15 IR 2589; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-40-5 Qualifications for approved instructor

Authority: IC 27-1-3-7
Affected: IC 27-1-15.5

Sec. 5. (a) An approved instructor must meet the following criteria:

(1) hold a high school diploma; and

(2) acquired the following experience:

(A) a valid teaching certificate for two (2) or more years; or

(B) two (2) or more years of managerial, supervisory or teaching experience in the insurance industry; or

(C) earned the designation of CLU, CPCU, FLMI, CIC or CHFC.

(b) No person may qualify as an approved instructor who:

(1) has been convicted of a crime involving moral turpitude; or

(2) has had his/her insurance agents license suspended or revoked in Indiana or in any other state; or

(3) at the time of application, has outstanding any fines imposed by the commissioner for insurance related disciplinary offenses; or

(4) is on the most recent tax warrant list supplied to the commissioner by the department of state revenue.

(Department of Insurance; 760 IAC 1-40-5; filed Jan 7, 1988, 1:43 pm: 11 IR 1589; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-40-5.1 Renewal for approved instructor

Authority: IC 27-1-3-7
Affected: IC 27-1-15.5

Sec. 5.1. (a) Qualification of an approved instructor is valid for three (3) years from the date of the approval by the commissioner of the instructor's most recent application to qualify as an instructor.

(b) An approved instructor who desires to renew qualification to be an instructor shall submit to the commissioner no later than sixty (60) days prior to the expiration of the instructor's qualification, the following:

(1) An application for renewal of approval as an instructor.

(2) A renewal fee.

(c) Approval for a qualified instructor is valid only for the registered insurance agent program for which the applicant is to be affiliated, as indicated on the application.

(d) An approved instructor may transfer to a registered insurance agent program other than that for which the instructor is approved only after:

(1) written approval of the commissioner; and

(2) payment of a transfer fee to the commissioner.

(e) An approved instructor may obtain approval to be an instructor at a registered agent program additional to that for which the instructor is approved only after:

(1) submission of an application for additional approval; and

(2) payment of an additional approval fee to the commissioner.

(Department of Insurance; 760 IAC 1-40-5.1; filed Aug 4, 1992, 5:00 p.m.: 15 IR 2589; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-40-6 Educational requirements

Authority: IC 27-1-3-7
Affected: IC 27-1-15.5-4

Sec. 6. (a)(1) To qualify as a registered insurance agent program for life insurance pre-licensing education, the program shall include instruction in the following areas of study and for each of these areas, shall provide not less than the smaller of the below designated number of hours of instruction:

I. Introduction to Life Insurance — 5-7 Hours
- Function of Life Insurance
- Life Insurance and Annuities
- Life Insurance Classifications
- Forms of Life Insurance
- Kinds of Policies
- Registered Products
- New Developments in Policies

II. Life Insurance as a Contract — 5-7 Hours
- General Provisions
- Non-forfeiture Values
- Dividends
- Optional Provisions

III. Special Life Policies — 5-7 Hours
- Mortgage Redemption
- Family Maintenance
- Family Income

- Modified Whole Life
- Universal Life

IV. Special Annuities 2-3 Hours
- Joint and Survivor
- Variable
- Guaranteed for Period Certain

V. Ethics, Insurance Laws and Regulations 4-6 Hours
- Indiana Insurance Laws and Regulations
- Registered Products Regulations
- Ethical Practices in Sales and Marketing
- Code of Professional Conduct

TOTAL HOURS 24 Hours

(2) Nothing in this section shall preclude a registered insurance agent program from offering additional or supplemental materials or instruction in the area of life insurance, provided, however, that the program continues to meet the requirements set forth in part (1) of this section *[subdivision (1)]*.

(3) A certificate of pre-licensing course completion may be accepted only if the applicant and the instructor certify to the commissioner that:

(1) the applicant has satisfactorily completed the minimum required course studies totaling not less than twenty-four (24) hours; and

(2) the applicant has been present in a structured setting with an approved instructor for not less than a total of twenty-four (24) hours.

(b)(1) To qualify as a registered insurance agent program for health insurance pre-licensing education, the program shall include instruction in the following areas of study and for each of these areas, shall provide not less than the smaller of the below designated number of hours of instruction:

I. Introduction to Health Insurance 6-8 Hours
- The General Nature of Health Insurance
- Importance of Health Insurance in Family Financial Planning

II. Disability Insurance 6-8 Hours
- The General Nature of Disability Insurance
- The Need for Disability Income
- Disability Income Policies
- Individual vs. Group Policies
- Cost of Policies
- Important Exclusions

III. Medical Insurance 5-7 Hours
- Kinds of Insurers
- General Provisions of Policies
- Service Providers
- Indemnity Policies
- Health Maintenance Organizations
- Individual vs. Group Contracts

IV. Ethics, Insurance Laws & Regulations 4-6 Hours
- Indiana Insurance Laws & Regulations
- Ethical Practices in Sales & Marketing
- Codes of Professional Conduct

TOTAL HOURS 24 Hours

(2) Nothing in this section shall preclude a registered insurance agent program from offering additional or supplemental materials or instruction in the area of health insurance, provided, however, that the program continues to meet the requirements set forth in part (1) of this section *[subdivision (1)]*.

(3) A certificate of pre-licensing course completion may be issued only if the applicant and the instructor certify to the commissioner that:

(1) the applicant has satisfactorily completed the minimum required course studies totaling not less than twenty-four (24) hours; and

(2) the applicant has been present in a structured setting with an approved instructor for not less than a total of twenty-four (24) hours.

(c)(1) To qualify as a registered insurance agent program for life and health insurance pre-licensing education, the program shall include instruction in the following areas of study, and for each of these areas, shall provide not less than the smaller of the below designated number of hours of instruction:

I. Introduction to Life Insurance 5-7 Hours
- Function of Life Insurance
- Life Insurance vs. Annuities
- Life Insurance Classifications
- Forms of Life Insurance
- Kinds of Policies
- Registered Products
- New Developments In Policies

II. Life Insurance as a Contract 5-7 Hours
- General Provisions
- Non-forfeiture Values
- Dividends
- Optional Provisions

III. Special Life Policies 5-7 Hours
- Mortgage Redemption
- Family Maintenance
- Family Income
- Modified Whole Life
- Universal Life

IV. Special Annuities 2-3 Hours
- Joint and Survivor
- Variable
- Guaranteed for Period Certain

V. Introduction to Health Insurance 4-6 Hours
- The General Nature of Health Insurance
- Importance of Health Insurance in Family Financial Planning

VI. Disability Insurance 5-7 Hours
- The General Nature of Disability Insurance
- The Need for Disability Income
- Disability Income Policies
- Individual vs. Group Policies
- Cost of Policies

- Important Exclusions

VII. Medical Insurance 4-6 Hours

- Kinds of Insurers
- General Provisions of Policies
- Service Providers
- Indemnity Policies
- Individual vs. Group Contracts

VIII. Ethics, Insurance Laws & Regulations 4-6 Hours

- Indiana Insurance Laws & Regulations
- Registered Products Regulations
- Ethical Practices in Sales & Marketing
- Codes of Professional Conduct

TOTAL HOURS 40 Hours

(2) Nothing in this section shall preclude a registered insurance agent program from offering additional or supplemental materials or instruction in the area of life and health insurance, provided, however, that the program continues to meet the requirements set forth in part (1) of this section *[subdivision (1)]*.

(3) A certificate of pre-licensing course completion may be issued only if the applicant and the instructor certify to the commissioner that:

(1) the applicant has satisfactorily completed the minimum required course studies totaling not less than forty (40) hours; and

(2) the applicant has been present in a structured setting with an approved instructor for not less than a total of forty (40) hours.

(d)(1) To qualify as a registered insurance agent program for property and casualty, pre-licensing education, the program shall include instruction in the following areas of study, and for each of these areas, shall provide not less than the smaller of the below designated number of hours of instruction:

I. History of Property Insurance 4-6 Hours

- Fire Insurance
- The Standard Fire Policy
- Forms
- Endorsements

II. The Home Owners Policy 4-6 Hours

- History, General Nature, Section I
- Coverages, Perils Insured
- Optional Coverages

III. The Personal Auto Policy 4-6 Hours

- Liability Coverage
- Medical Payments Coverage
- Uninsured/Underinsured Motorist Coverage
- Collision Coverage
- Comprehensive Coverage
- Financial Responsibility Requirements
- Definitions, Policy Provisions, Rights and Duties Under the Policy
- Cancellation/Non-Renewal
- Automobile Insurance Plan (AIP)

IV. Other Personal Property Insurance 4-6 Hours

- Dwelling Fire, Mobile Home, Flood Personal Marine
- Title Insurance

V. Commercial Property Insurance 5-7 Hours
- New ISO Program
- Coverage Forms, Indirect Loss
- Boiler and Machinery, Marine
- Dishonesty Insurance, Package Policy

VI. Negligence of Legal Liability 4-6 Hours
- Tortious Acts, Obligations of Property
- Owners, Defenses against Liability Claims

VII. Personal Liability Insurance 3-5 Hours
- Section II of the Homeowners Policy
- Personal Liability and Medical Payments
- Professional Liability
- Umbrella Liability

VIII. Commercial Liability Insurance 5-7 Hours
- General Liability Insurance, the ISO Claims Made vs. Occurrence
- Forms, Commercial Auto, Aviation, Umbrella
- Workers Compensation

IX. Ethics, Insurance Laws & Regulations 4-6 Hours
- Indiana Insurance Laws & Regulations
- FAIR Plan, Assigned Risk, Voluntary Market Plan, Residual Markets
- Ethical Practices in Sales & Marketing
- Codes of Professional Conduct

TOTAL HOURS 40 Hours

(2) Nothing in this section shall preclude a registered insurance agent program from offering additional or supplemental materials or instruction in the area of property and casualty insurance provided, however, that the program continues to meet the requirements set forth in part (1) of this section *[subdivision (1)]*.

(3) A certificate of pre-licensing course completion may be issued only if the applicant and the instructor certify to the commissioner that:

(A) the applicant has satisfactorily completed the minimum required course studies totaling not less than forty (40) hours; and

(B) the applicant has been present in a structured setting with an approved instructor for not less than a total of forty (40) hours.

(Department of Insurance; 760 IAC 1-40-6; filed Jan 7, 1988, 1:43 p.m.: 11 IR 1589; filed Aug 15, 1988, 4:00 p.m.: 12 IR 25; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-40-7 Time, place of course offering

Authority: IC 27-1-3-7
Affected: IC 27-1-15.5

Sec. 7. (a) The director of a registered insurance agent program may determine the hours and location where its program may be offered, provided, however, that all such times and locations shall be reported to the commissioner not less than 15 days before the beginning of the course.

(b) The commissioner may refuse to accept a certificate of course completion:

(1) unless on the form provided by the commissioner, the approved instructor and the applicant certify under penalties of perjury that the applicant has received the minimum required hours of instruction at the location and times indicated on the application; or

(2) if, after notice and opportunity for hearing, the commissioner finds that an applicant has completed fewer than the minimum number of hours of instruction or that the instruction was received at a location or at a time or place other than that reported to the commissioner under part (a) of this section *[subsection (a) of this section]*.

(Department of Insurance; 760 IAC 1-40-7; filed Jan 7, 1988, 1:43 pm: 11 IR 1591; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-40-7.1 Certificates of course completion

Authority: IC 27-1-3-7
Affected: IC 27-1-15.5

Sec. 7.1. The commissioner shall make available to approved registered agent programs, certificates of course completion as follows:

(1) The minimum number of certificates of course completion which an approved registered agent program shall be issued at one (1) time is ten (10). An approved registered agent program may be issued any number of certificates of course completion more than the minimum as per request.

(2) Certificates of course completion issued to an approved registered agent program shall not be transferrable from the approved registered agent program to which the certificates of course completion were issued.

(3) Once issued, unused certificates of course completion shall not be returnable to the commissioner, nor shall a refund be available.

(4) Unused certificates of course completion issued to a registered agent program shall be valid only so long as the registered agent program to which the certificates of course completion were issued retains the commissioner's approval as set forth in sections 3 and 3.1 of this rule.

(5) An approved registered agent program shall issue only one (1) certificate of course completion per individual per actual completion. Renewals of certificate or course completion shall not be accepted.

(Department of Insurance; 760 IAC 1-40-7.1; filed Aug 4, 1992, 5:00 p.m.: 15 IR 2590; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-40-8 Enforcement

Authority: IC 27-1-3-7
Affected: IC 27-1-15.5

Sec. 8. (a) The commissioner may after notice and opportunity for a hearing, withhold, suspend, or revoke the registration of a program or the approval of an instructor or director if the commissioner finds that the director or instructor has made a material misrepresentation on the application for program approval, on the application for program director approval, or on the certificate of pre-licensing course completion.

(b) The commissioner may, after notice and opportunity for a hearing, deny, suspend, or revoke the license of an applicant or agent if the commissioner finds that the applicant or agent has made a material misrepresentation on the certificate of pre-licensing course completion.

(c) As used in this section, the term "material misrepresentation" means a false or misleading statement of fact or the omission of any fact which if known to the commissioner, would be cause to suspend, revoke, or refuse to grant approval or certification under this rule, or which would otherwise render such person or organization ineligible for the approval or certification for which application was made. *(Department of Insurance; 760 IAC 1-40-8; filed Jan 7, 1988, 1:43 p.m.: 11 IR 1592; filed Aug 15, 1988, 4:00 p.m.: 12 IR 28; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-40-9 Fees

Authority: IC 27-1-15.5-7.7
Affected: IC 27-1-15.5-7.7

Sec. 9. (a) All certificates of completion shall be purchased by the agent education program director from the commissioner at the cost of five dollars ($5) each. The program director shall be reimbursed by each applicant for the cost of the certificate of completion.

(b) The submission of a certificate of completion shall constitute certification by the program director that the five dollar ($5) application fee has been paid to the commissioner. No copy or reproduction of an original authorized certificate of completion shall be valid without the prior written approval of the commissioner upon verification that the application fee has been paid. *(Department of Insurance; 760 IAC 1-40-9; filed Jan 7, 1988, 1:43 p.m.: 11 IR 1592; filed Aug 4, 1992, 5:00 p.m.: 15 IR 2590; filed Sep 5, 1996, 11:00 a.m.: 20 IR 15; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-40-10 Form; certificate of completion of agent pre-licensing education course (Repealed)

Sec. 10. *(Repealed by Department of Insurance; filed Aug 15, 1988, 4:00 p.m.: 12 IR 28)*

760 IAC 1-40-10.1 Forms

Authority: IC 27-1-3-7
Affected: IC 27-1-15.5

Sec. 10.1. The commissioner shall prepare and distribute such forms and certificates which, is *[sic.]* his discretion, are reasonable or necessary to carry out the requirements of this rule. *(Department of Insurance; 760 IAC 1-40-10.1; filed Aug 15, 1988, 4:00 p.m.: 12 IR 28; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-40-11 Form; application for instructor approval (Repealed)

Sec. 11. *(Repealed by Department of Insurance; filed Aug 15, 1988, 4:00 p.m.: 12 IR 28)*

760 IAC 1-40-12 Form; application for program director approval (Repealed)

Sec. 12. *(Repealed by Department of Insurance; filed Aug 15, 1988, 4:00 p.m.: 12 IR 28)*

760 IAC 1-40-13 Form; application for program approval to conduct insurance pre-licensing education course(s) (Repealed)

Sec. 13. *(Repealed by Department of Insurance; filed Aug 15, 1988, 4:00 p.m.: 12 IR 28)*

760 IAC 1-40-14 Form; request for waiver of pre-licensing education requirement (Repealed)

Sec. 14. *(Repealed by Department of Insurance; filed Aug 15, 1988, 4:00 p.m.: 12 IR 28)*

Rule 41. Insurance Administrators

760 IAC 1-41-1 Authority for rule

Authority: IC 27-1-25-14
Affected: IC 27-1-25-11

Sec. 1. This rule (760 IAC 1-41) is promulgated by the commissioner of insurance pursuant to IC 27-1-25-11 and IC 27-1-25-14. *(Department of Insurance; 760 IAC 1-41-1; filed Sep 9, 1988, 2:10 p.m.: 12 IR 24; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-41-2 Financial statement

Authority: IC 27-1-25-14
Affected: IC 27-1-25-11

Sec. 2. Each application for issuance of a certificate of registration or renewal of a certificate of registration shall be accompanied by the applicant's current financial statement. A financial statement, for purposes of this rule, consists of a financial statement that is prepared in a manner consistent with generally accepted accounting principles (GAAP) and is accompanied by either an opinion by an independent accounting firm or a statement by an officer of the entity being registered as an administrator, representing that the financial statement was prepared in a manner consistent with GAAP and accurately reflects the financial condition of the entity. The financial statement must reflect a positive net worth in order to be acceptable as proof of the applicant's financial responsibility. *(Department of Insurance; 760 IAC 1-41-2; filed Sep 9, 1988, 2:10 p.m.: 12 IR 24; filed Feb 8, 1990, 5:00 p.m.: 13 IR 1175, eff Mar 1, 1990 [IC 4-22-2-36 suspends the effectiveness of a rule document for thirty (30) days after filing with the secretary of state. LSA Document #89-139 was filed Feb 8, 1990.]; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-41-3 Certificate of registration; date of issue, expiration and renewal

Authority: IC 27-1-25-14
Affected: IC 27-1-25

Sec. 3. (a) Every administrator who has complied with the requirements of Indiana Code Chapter 27-1-25 and this rule shall be issued a certificate of registration. A certificate of registration issued to a first-time applicant shall be effective as of the date of approval of the application and shall expire on the next following June 30.

(b) All certificates of registration will expire on June 30 of each year and must be renewed on an annual basis. Applications for renewal of registration, on forms approved by the commissioner, will be mailed to all current certificate holders at the last address as shown in the commissioner's records, no later than March 1 of each year. Applications for renewal along with any other required documents must be received no later than May 1. Renewal certificates will be issued on July 1 of each year. *(Department of Insurance; 760 IAC 1-41-3; filed Sep 9, 1988, 2:10 p.m.: 12 IR 24; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-41-4 Bond or cash deposit

Authority: IC 27-1-25-14
Affected: IC 27-1

Sec. 4. (a) Every administrator shall file and maintain with the commissioner, as obligee, a surety bond, issued by a surety company authorized to transact business in this state. The amount of the bond shall be not less than ten percent (10%) of the amount of total funds handled involving Indiana residents or twenty-five thousand dollars ($25,000), whichever is greater, but the amount of the bond shall not exceed two hundred thousand dollars ($200,000). For purposes of fixing the amount of the bond, the amount of total funds handled is determined by the amount of premium collected or the amount in dollars of administered claims handled during the preceding calendar year, whichever is greater, involving Indiana residents, as shown by the financial statement filed with the commissioner. If no funds were handled during the preceding year, the amount of the bond is twenty-five thousand dollars ($25,000). The bond must be on a form approved by the commissioner.

(b) An administrator may furnish a cash deposit to meet the requirements of this section. Said cash deposit shall be in the form of a certificate of deposit and must be held jointly in the name of the administrator and the commissioner. The amount of any such cash deposit shall be fixed in the same manner as the amount of a surety bond, as described in subsection (a). When an administrator is affiliated with an authorized insurer, such insurer may satisfy the administrator's cash deposit requirement by adding to the insurer's required deposits pursuant to IC 27-1-6-14, IC 27-1-6-15, and IC 27-1-12-11, the amount required to satisfy the requirements of this section. All income from a deposit required by this section belongs to the depositing administrator or insurer and may be paid to it as it becomes available.

(c) If an administrator is covered by a bond required by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1112, because the administrator is providing services to or for the benefit of an employee benefit plan, as that term is defined in 29 U.S.C. 1002(1), the administrator's bond coverage will be deemed to meet the requirements of this section, but only to the extent that the administrator is providing services to or for the benefit of such employee benefit plans. To the extent that an

administrator's activities are not subject to ERISA, the requirements of subsection (a) will apply.

(d) Any administrator seeking to have bond coverage under ERISA deemed to meet the requirements of this section, pursuant to subsection (c), shall provide verification to the commissioner, annually at the time of submission of the administrator's application, on a form prescribed by the commissioner, an affidavit that sets forth the following:

(1) The amount of funds handled in the preceding calendar year.

(2) The percentage of funds handled directly attributable to ERISA plans.

A copy of the bond or bonds providing coverage to the administrator shall be attached to the affidavit. The burden of establishing proof of coverage under a bond or bonds required by ERISA pursuant to subsections (c) through (d) *[this subsection]* is that of the administrator. *(Department of Insurance; 760 IAC 1-41-4; filed Sep 9, 1988, 2:10 p.m.: 12 IR 24; filed Feb 8, 1990, 5:00 p.m.: 13 IR 1176, eff Mar 1, 1990 [IC 4-22-2-36 suspends the effectiveness of a rule document for thirty (30) days after filing with the secretary of state. LSA Document #89-139 was filed Feb 8, 1990.]; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-41-5 Effective date

Authority: IC 27-1-25-14
Affected: IC 27-1-25-11

Sec. 5. This rule shall become effective on March 1, 1990, and shall apply to any new applicant for a certificate of registration making application on or after that date. For administrators holding a certificate of registration prior to the effective date, this rule shall apply no sooner than the administrators' 1990 renewal date. *(Department of Insurance; 760 IAC 1-41-5; filed Feb 8, 1990, 5:00 p.m.: 13 IR 1176, eff Mar 1, 1990 [IC 4-22-2-36 suspends the effectiveness of a rule document for thirty (30) days after filing with the secretary of state. LSA Document #89-139 was filed Feb 8, 1990.]; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 42. Medicare Supplement Transition (Repealed)

(Repealed by Department of Insurance; filed May 1, 1990, 10:40 a.m.: 13 IR 1720)

Rule 42.1. Medicare Supplement Insurance Transition (Repealed)

(Repealed by Department of Insurance; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2618)

Rule 43. Long-Term Health Care Insurance (Repealed)

(Repealed by Department of Insurance; filed Oct 30, 1992, 12:00 p.m.: 16 IR 870)

Rule 44. Life Reinsurance Agreements (Repealed)

(Repealed by Department of Insurance; filed Nov 14, 1994, 10:30 a.m.: 18 IR 870)

Rule 45. Medicare Supplement Insurance (Repealed)

(Repealed by Department of Insurance; filed Aug 18, 1990, 5:00 p.m.: 14 IR 154, eff Oct 1, 1990)

Rule 45.1. Medicare Supplement Insurance (Repealed)

(Repealed by Department of Insurance; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2618)

Rule 46. Registration of Utilization Review Agents

760 IAC 1-46-1 Authority

Authority: IC 27-8-17-20
Affected: IC 27-8-17-20

Sec. 1. This rule is adopted and promulgated by the department of insurance under IC 27-8-17-20. *(Department of Insurance; 760 IAC 1-46-1; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1391; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-46-2 Definitions

Authority: IC 27-8-17-20
Affected: IC 27-8-17

Sec. 2. The definitions in IC 27-8-17 shall apply to all provisions contained in this rule. *(Department of Insurance; 760 IAC 1-46-2; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1391; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-46-3 Certification of utilization review agents

Authority: IC 27-8-17-20
Affected: IC 4-21.5; IC 27-8-17-19

Sec. 3. (a) An application for certification of a utilization review agent must be filed with the department of insurance at 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204. Initial applications must be filed on or before February 28, 1993.

(b) The application must be submitted on a utilization review agent application form that can be obtained from the department of insurance. The application form is adopted by reference, and a copy may be obtained from the Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204.

(c) The completed application form shall be accompanied by a description of the utilization review plan that shall summarize the following information:

(1) Procedures established for appeal of an adverse determination. These procedures must comply with section 6 of this rule.

(2) Procedures established for handling complaints by enrollees, patients, or health care providers. These procedures must comply with section 9 of this rule.

(3) Policies and procedures that ensure that all applicable state and federal laws to protect the confidentiality of medical records are followed. These procedures must comply with section 8 of this rule.

(d) The completed application form shall contain the following information:

(1) A certification that the utilization review agent will comply with the provisions of IC 27-8-17.

(2) The categories of persons employed to perform utilization review. Personnel changes within the categories do not constitute a material change in the application.

(3) A description of the hours of operation within the state of Indiana and how the utilization review agent may be contacted during weekends and holidays. This description must be in compliance with section 7 of this rule.

(4) Representative samples of materials provided by the utilization review agent or applicant to inform its clients, enrollees, or providers of the requirements of the utilization review plan.

(5) A certification that the utilization review agent is in compliance with IC 27-8-17-19.

(e) The utilization review agent shall report any material changes in the information in the application or renewal form referred to in this section not later than the thirtieth day after the date on which the change takes effect.

(f) The application process shall be as follows:

(1) The department of insurance shall have thirty (30) days after receipt of an application to determine whether the application is complete. In the event that an application is found to be incomplete, the department of insurance will give the applicant written notice of the required information necessary to complete the application. If the application is complete, the applicant will be advised that the application has been received and accepted for review.

(2) The department of insurance shall have sixty (60) days from the date the application is determined to be complete under subdivision (1) to process the application and approve or disapprove it. The department of insurance shall give the applicant written notice of any deficiencies noted as a result of the review conducted under this subdivision.

(3) The department of insurance shall afford the applicant an opportunity for a meeting to discuss any omissions or deficiencies noted.

(4) The applicant must correct the omissions or deficiencies in the application within thirty (30) days of the date of the latest notice of the department of insurance of such omissions or deficiencies. If the applicant fails to do so, the application file will be closed as an incomplete application. The application fee will not be refundable.

(5) The department of insurance shall maintain an application file which shall contain the application, notices of omissions or deficiencies, responses, and any written materials generated by any person who was considered by the department of insurance in evaluating the application.

(g) A utilization review agent must apply for a certificate renewal every year, not later than June 30. The initial renewal shall be completed by June 30, 1994. A renewal form must be used for this purpose. The renewal fee must be submitted with the renewal form. The renewal form can be obtained from the department of insurance at the address listed in subsection (a). The completed renewal form and the renewal fee must be submitted to the department of insurance at the address listed in subsection (a). A utilization review agent may continue to operate under its certificate after a completed renewal application form and the renewal fee has been timely received by the department of insurance until the renewal is finally denied or issued by the department of insurance. If a completed renewal application and fee is not received prior to June 30, the certificate will automatically be canceled, and the utilization review agent must complete and submit a new application form with the new application fee for another certificate of registration.

(h) If an application or renewal is initially denied under this section, the applicant or registrant may appeal such denial under the terms of the provisions of IC 4-21.5. A hearing of such appeal shall be conducted within forty-five (45) days from the date the petition for hearing is filed with the commissioner. A decision by the commissioner shall be rendered within sixty (60) days from the date of the hearing.

(i) Applications that are filed on or before February 28, 1993, will be processed on a first in, first out basis by the department of insurance. The time lines set out for processing applications in subsection (f) will not apply to these applications.

(j) Entities who were operating in Indiana as utilization review agents on or after July 1, 1992, must file the application described in subsections (a) through (d) by February 28, 1993. Those entities may continue to operate as utilization review agents pending review of the application unless they are advised in writing that the application has been disapproved or closed as an incomplete application as described in subsection (f). No entity may continue to operate after fifteen (15) days from the date of the notice of the denial or closure of the file. *(Department of Insurance; 760 IAC 1-46-3; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1392; errata filed Feb 10, 1993, 4:00 p.m.: 16 IR 1514; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-46-4 General standards of utilization review

Authority: IC 27-8-17-20
Affected: IC 27-8-17

Sec. 4. The utilization review plan, including appeal requirements, shall be conducted in accordance with standards or guidelines developed with input from appropriate health care providers and approved by a physician. The utilization review plan shall include the following components:

(1) Written procedures for:

(A) Notification of the utilization review agent's determinations provided to the enrollee, a person acting on behalf of the enrollee, or the enrollee's provider of record as addressed in section 5 of this rule.

(B) Appeal of an adverse determination and a copy of any forms used during the appeal process, as required by section 6 of this rule.

(C) Receiving or redirecting toll free telephone calls during normal business hours and after hour calls, either in person or by recording, and assurance that a toll free number will be maintained forty (40) hours per week during normal business hours as addressed in section 7 of this rule.

(D) Reviewing, including the following:

(i) Any form used during the review process.

(ii) Time frames that shall be met during the review.

(E) Handling of written complaints by enrollees, patients, or health care providers, as addressed in section 9(a) of this rule.

(F) Determining if health care providers utilized by the utilization review agent are licensed.

(G) Orientation and training of personnel who perform utilization review.

(H) Assuring that patient-specific information obtained during the process of utilization review, as addressed in section 8 of this rule, will be:

(i) kept confidential in accordance with applicable federal and state laws;

(ii) used for purposes of utilization review, quality assurance, discharge planning, and catastrophic case management;

(iii) shared with only those agencies (such as the claims administrator) that have authority to receive such

information; and

(iv) summary data shall not be considered confidential if it does not provide sufficient information to allow for identification of individual patients.

(2) Each utilization review agent shall utilize written screening criteria and review procedures that are established and periodically evaluated and updated with appropriate involvement from health care providers. Such written screening criteria and review procedures shall be available for review and inspection by the commissioner or a designated department of insurance representative and copying, as necessary, for the commissioner to carry out his or her lawful duties under the Insurance Code, provided; however, that any information obtained or acquired under the authority of this rule and IC 27-8-17 is confidential and privileged and not subject to the open records law or subpoena except to the extent necessary for the commissioner to enforce this rule and IC 27-8-17.

(3) Utilization review decisions shall be made in accordance with standards or guidelines that are developed with input from appropriate health care providers and approved by a physician.

(Department of Insurance; 760 IAC 1-46-4; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1393; errata filed Feb 10, 1993, 4:00 p.m.: 16 IR 1514; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-46-5 Notice of determinations made by utilization review agents

Authority: IC 27-8-17-20
Affected: IC 27-8-17-11

Sec. 5. In making a determination on whether to certify an admission, a utilization review agent shall comply with all provisions contained in IC 27-8-17-11. *(Department of Insurance; 760 IAC 1-46-5; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1393; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-46-6 Appeal of adverse determination of utilization review agents

Authority: IC 27-8-17-20
Affected: IC 27-8-17-12

Sec. 6. A utilization review agent shall comply with all provisions of IC 27-8-17-12 in establishing an appeal procedure for adverse determinations. *(Department of Insurance; 760 IAC 1-46-6; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1394; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-46-7 Utilization review agent's telephone access

Authority: IC 27-8-17-20
Affected: IC 27-8-17-9

Sec. 7. (a) A utilization review agent shall have personnel available by toll free telephone at least forty (40) hours per week during normal business hours.

(b) A utilization review agent must have a telephone system capable of accepting, recording, or providing instructions to incoming calls during other than normal business hours and shall respond to such calls not later than two (2) working days after the date on which the call was received. *(Department of Insurance; 760 IAC 1-46-7; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1394; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-46-8 Confidentiality

Authority: IC 27-8-17-20
Affected: IC 27-8-17

Sec. 8. (a) A utilization review agent shall preserve the confidentiality of individual medical records to the extent required by state and federal laws.

(b) To assure confidentiality, a utilization review agent must, when contacting a health care provider's office or hospital, provide its certification number and the caller's name to the provider's named utilization review representative in the health care

provider's office.

(c) Medical records and patient-specific information shall be maintained by the utilization review agent in a secure area with access limited to utilization review personnel only.

(d) Information generated and obtained by the utilization review agent in the course of utilization review shall be retained for at least two (2) years if the information relates to a case for which an adverse decision was made at any point or if the information relates to a case that may be reopened. *(Department of Insurance; 760 IAC 1-46-8; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1394; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-46-9 Complaints and information

Authority: IC 27-8-17-20
Affected: IC 27-8-17

Sec. 9. (a) Within a reasonable time period, upon receipt of a written complaint alleging a violation of this section or IC 27-8-17 by a utilization review agent, from an enrollee's health care provider, a person acting on behalf of the enrollee, or the enrollee, the commissioner or a designated department of insurance representative shall investigate the complaint and furnish a written response to the complainant and the utilization review agent named. The response will not identify in any manner, the patient or patients without written consent. This response must include the following:

(1) A statement of the original complaint.

(2) A copy of any written response by the utilization review agent. The written response should not contain privileged medical records. If it is necessary to refer to medical records, they shall be separately forwarded with the response and clearly marked as privileged medical records.

(3) A statement of the findings of the commissioner or a designated department of insurance representative and an explanation of the basis of such findings.

(4) Corrective actions, if any, on the part of the utilization review agent that the commissioner or a designated department of insurance representative finds appropriate.

(5) A time frame in which any corrective actions should be completed. The utilization review agent will provide evidence of corrective action within the specified time frame to the commissioner or a designated department of insurance representative.

(b) In addition to the authority of the commissioner to respond to complaints described in subsection (a), the department of insurance is authorized to address inquiries to utilization review agents that the department of insurance may deem necessary for the public good or for a proper discharge of its duties. It shall be the duty of the agent to promptly answer such inquiries in writing.

(c) The commissioner shall maintain and update a list of utilization review agents issued certificates, including certificate numbers and the renewal date for those certificates. The commissioner shall provide the list at cost to all individuals or organizations requesting the list.

(d) Requirements for on-site review by the department of insurance shall be as follows:

(1) The commissioner or a designated department of insurance representative is authorized to make a complete on-site review of the operations of each utilization review agent at the principal place of business for such agent as often as is deemed necessary.

(2) Utilization review agents will be notified of the scheduled on-site visit by letter which will specify, as a minimum, the identity of the commissioner's designated department of insurance representative and the expected arrival date and time.

(3) The utilization review agent must make available during such on-site visits all records relating to its operation.

(4) The commissioner or the designated department of insurance representative may perform periodic telephone audits of utilization review agents authorized to conduct business in this state to determine if the agents are reasonably accessible.

(Department of Insurance; 760 IAC 1-46-9; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1394; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-46-10 Administrative violations

Authority: IC 27-8-17-20
Affected: IC 27-8-17-17

Sec. 10. If the commissioner, through the commissioner's designated representative, believes that a utilization review agent

may have violated, or is violating, this section or IC 27-8-17, the commissioner's designated representative shall comply with IC 27-8-17-17 in investigating the complaint and, where appropriate, in imposing sanctions against the utilization review agent. *(Department of Insurance; 760 IAC 1-46-10; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1395; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-46-11 Fees

Authority: IC 27-8-17-9; IC 27-8-17-20
Affected: IC 27-8-17-10

Sec. 11. (a) The fee for initial application for certification as a utilization review agent is one hundred fifty dollars ($150).

(b) The annual renewal fee for a certificate as a utilization review agent is one hundred dollars ($100). *(Department of Insurance; 760 IAC 1-46-11; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1395; errata filed Feb 10, 1993, 4:00 p.m.: 16 IR 1514; filed Sep 5, 1996, 11:00 a.m.: 20 IR 16; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 47. Continuing Education (Repealed)

(Repealed by Department of Insurance; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1829)

Rule 48. Standards for Accelerated Benefit Provisions of Individual and Group Life Insurance Policies and Required Disclosure

760 IAC 1-48-1 Purpose; scope

Authority: IC 27-1-3-7
Affected: IC 27-1-12; IC 27-8-12

Sec. 1. (a) This rule sets forth the standards for accelerated benefit provisions of individual and group life insurance policies and provides required standards of disclosure.

(b) This rule applies to all accelerated benefit provisions of individual and group life insurance policies issued or delivered in Indiana on or after the effective date of this rule, except those policies subject to IC 27-8-12. *(Department of Insurance; 760 IAC 1-48-1; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1821; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-48-2 Definitions

Authority: IC 27-1-3-7
Affected: IC 27-1-12

Sec. 2. (a) As used in this rule, "accelerated benefits" refers to those benefits under a life insurance contract that:

(1) are payable to a policy owner or certificate holder, during the lifetime of the insured, in anticipation of death or upon the occurrence of specified life threatening or catastrophic conditions as defined by the policy or rider;

(2) reduce the death benefit otherwise payable under the life insurance contract; and

(3) are payable upon the occurrence of a single qualifying event that results in the payment of a benefit amount fixed at the time of acceleration.

(b) As used in this rule, "qualifying event" means one (1) or more of the following:

(1) A medical condition that would result in a drastically limited life span as specified in the contract, for example, twenty-four (24) months or less.

(2) A medical condition that has required or requires extraordinary medical intervention, such as, but not limited to, major organ transplant or continuous artificial life support, without which the insured would die.

(3) Any condition that usually requires continuous confinement in an eligible institution as defined in the contract if the insured is expected to remain there for the rest of his or her life.

(4) A medical condition which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span, such as, but not limited to, one (1) or more of the following:

(A) Coronary artery disease resulting in an acute infarction or requiring surgery.

(B) Permanent neurological deficit resulting from cerebral vascular accident.
(C) End stage renal failure.
(D) Acquired immune deficiency syndrome.
(E) Other medical conditions which the commissioner of the department of insurance may approve for any particular filing.

(5) Other qualifying events that the commissioner of the department of insurance may approve for any particular filing.

(Department of Insurance; 760 IAC 1-48-2; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1821; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-48-3 Type of product

Authority: IC 27-1-3-7
Affected: IC 27-1-12

Sec. 3. Accelerated benefit riders and life insurance policies with accelerated benefit provisions are primarily mortality risks rather than morbidity risks. They are life insurance benefits subject to IC 27-1-12. *(Department of Insurance; 760 IAC 1-48-3; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1822; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-48-4 Assignee; beneficiary

Authority: IC 27-1-3-7
Affected: IC 27-1-12

Sec. 4. Prior to the payment of the accelerated benefit, the insurer must obtain from any assignee or irrevocable beneficiary a signed acknowledgement of concurrence for payout. If the insurer making the accelerated benefit is itself the assignee under the policy, no such acknowledgement is required. *(Department of Insurance; 760 IAC 1-48-4; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1822; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-48-5 Criteria for payment

Authority: IC 27-1-3-7
Affected: IC 27-1-12

Sec. 5. The following criteria for payment apply:

(1) Contract payment options shall include the option to take the benefit as a lump sum. The benefit shall not be made available as an annuity contingent upon the life of the insured.

(2) No restrictions are permitted on the use of the proceeds.

(3) If any death benefit remains after payment of an accelerated benefit, the accidental death benefit provision, if any, in the policy or rider shall not be affected by the payment of the accelerated benefit.

(Department of Insurance; 760 IAC 1-48-5; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1822; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-48-6 Disclosures

Authority: IC 27-1-3-7
Affected: IC 27-1-12

Sec. 6. (a) The terminology "accelerated benefit" shall be included in the descriptive title. Products subject to this rule shall not be described or marketed as long term care insurance or as providing long term care benefits.

(b) A disclosure statement that receipt of these accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

(c) The following disclosure requirements apply:

(1) A written disclosure including, but not necessarily limited to, a brief description of the accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefits shall be given to the applicant. The description shall include an explanation of any effect of the payment of a benefit on the policy's cash value, accumulation account, death benefit, premium, policy loans, and policy liens. In addition, the following apply:

(A) In the case of agent solicited insurance, the agent shall provide the disclosure form to the applicant prior to or concurrently with the application. Acknowledgement of the disclosure shall be signed by the applicant and writing agent.

(B) In the case of a solicitation by direct response methods, the insurer shall provide the disclosure form to the applicant at the time the policy is delivered, with a notice that a full premium refund shall be received if the policy is returned to the company within the free look period.

(C) In the case of group insurance policies, the disclosure form shall be contained as part of the certificate of coverage or any related document furnished by the insurer for the certificate holder.

(2) If there is a premium or cost of insurance charge, the insurer shall give the applicant a generic illustration numerically demonstrating any effect of the payment of a benefit on the policy's cash value, accumulation account, death benefit, premium, policy loans, and policy liens. In addition, the following apply:

(A) In the case of agent solicited insurance, the agent shall provide the illustration to the applicant prior to or concurrently with the application.

(B) In the case of a solicitation by direct response methods, the insurer shall provide the illustration to the applicant at the time the policy is delivered.

(C) In the case of group insurance policies, the illustration form shall be contained as part of the certificate of coverage or any related document furnished by the insurer for the certificate holder.

(3) The following disclosure of premium charges apply:

(A) Insurers with financing options other than as described in section 10(a)(2) and 10(a)(3) of this rule shall disclose to the policy owner any premium or cost of insurance charge for the accelerated benefit. These insurers shall make a reasonable effort to assure that the certificate holder is aware of any additional premium or cost of insurance charge if the certificate holder is required to pay such charge.

(B) Insurers shall furnish an actuarial demonstration to the insurance department when filing the product disclosing the method of arriving at their cost for the accelerated benefit.

(4) The insurer shall disclose to the policy owner any administrative expense charge. The insurer shall make a reasonable effort to assure that the certificate holder is aware of any administrative expense charge if the certificate holder is required to pay such charge.

(d) When a policy owner or certificate holder requests an acceleration, the insurer shall send a statement to the policy owner or certificate holder and irrevocable beneficiary showing any effect that the payment of the accelerated benefit will have on the policy's cash value, accumulation account, death benefit, premium, policy loans, and policy liens. Also, the statement must show the effect that a policy loan and a partial withdrawal, if available, would have on the policy's cash value, accumulation account, death benefit, premiums, and policy loans. The statement shall disclose that receipt of accelerated benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements. In addition, the statement shall disclose that receipt of any accelerated benefit payment may be taxable and that assistance should be sought from a personal tax advisor. When a previous disclosure statement becomes invalid as a result of an acceleration of the death benefit, the insurer shall send a revised disclosure statement to the policy owner or certificate holder and irrevocable beneficiary. When the insurer agrees to accelerate death benefits, the insurer shall issue an amended schedule page to the policyholder or notify the certificate holder under a group policy to reflect any new, reduced in-force face amount of the contract. *(Department of Insurance; 760 IAC 1-48-6; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1822; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-48-7 Effective date of the accelerated benefits

Authority: IC 27-1-3-7
Affected: IC 27-1-12

Sec. 7. (a) The contract shall provide that the accelerated benefit provision shall be effective for accidents occurring on or after the effective date of the policy or rider.

(b) The contract shall provide that the accelerated benefit provision is effective for illnesses occurring after a period of not longer than thirty (30) days following the effective date of the policy or rider. *(Department of Insurance; 760 IAC 1-48-7; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1823; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-48-8 Waiver of premium

Authority: IC 27-1-3-7
Affected: IC 27-1-12

Sec. 8. The insurer may offer a waiver of premium for the accelerated benefit provision in the absence of a regular waiver of premium provision being in effect. At the time the benefit is claimed, the insurer shall explain any continuing premium requirement to keep the policy in force. *(Department of Insurance; 760 IAC 1-48-8; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1823; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-48-9 Discrimination

Authority: IC 27-1-3-7
Affected: IC 27-1-12

Sec. 9. Insurers shall not:

(1) unfairly discriminate among insureds with differing qualifying events under the policy or among insureds with similar qualifying events covered under the policy; and

(2) apply further conditions on the payment of the accelerated benefits other than those conditions specified in the policy or rider.

(Department of Insurance; 760 IAC 1-48-9; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1823; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-48-10 Actuarial standards

Authority: IC 27-1-3-7
Affected: IC 27-1-12

Sec. 10. (a) The following financing options apply:

(1) The insurer may require a premium charge or cost of insurance charge for the accelerated benefit. These charges shall be based on sound actuarial principles. In the case of group insurance, the additional cost may also be reflected in the experience rating.

(2) The insurer may pay a present value of the face amount. The calculation shall be based on any applicable actuarial discount appropriate to the policy design. The interest rate or interest rate methodology used in the calculation shall be based on sound actuarial principles and disclosed in the contract or actuarial memorandum provided under section 11 of this rule. The maximum interest rate used shall be no greater than the greater of:

(A) the current yield on ninety (90) day treasury bills; or

(B) the current maximum statutory adjustable policy loan interest rate.

(3) The insurer may accrue an interest charge on the amount of the accelerated benefits. The interest rate or interest rate methodology used in the calculation shall be based on sound actuarial principles and disclosed in the contract or actuarial memorandum. The maximum interest rate used shall be no greater than the greater of:

(A) the current yield on ninety (90) day treasury bills; or

(B) the current maximum statutory adjustable policy loan interest rate.

The interest rate accrued on the portion of the accelerated benefits which limit the amount available as a policy loan shall be no more than the policy loan interest rate stated in the contract.

(b) Accelerated benefit payments may have the following effects on cash value:

(1) When payment of an accelerated benefit results in a reduction in the death benefit, there shall be no more than a pro rata reduction in the cash value based on the percentage of death benefits accelerated to produce the accelerated benefit payment.

(2) Alternatively, the payment of accelerated benefits, any administrative expense charges, any future premiums, and any

accrued interest can be considered a lien against the death benefit of the policy or rider. As long as such a lien is outstanding, access to the cash value, whether by surrender, partial withdrawal, or policy loan, may be restricted to any excess of the cash value over the sum of any outstanding policy loans and a pro rata portion of the cash value. At any point in time, such pro rata portion of the cash value shall be the cash value at that point times the ratio of the lien at that point divided by the insured's death benefit at that point.

(c) The payment of an accelerated benefit may not be required to be applied toward repaying an amount greater than a pro rata proportion of any outstanding policy loans. *(Department of Insurance; 760 IAC 1-48-10; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1823; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-48-11 Actuarial disclosure and reserves

Authority: IC 27-1-3-7
Affected: IC 27-1-12

Sec. 11. (a) A qualified actuary shall describe the accelerated benefits, the risks, the expected costs, and the calculation of statutory reserves in an actuarial memorandum accompanying each filing. The insurer shall maintain in its files descriptions of the bases and procedures used to calculate benefits payable under these provisions. These descriptions shall be made available for examination by the commissioner of the department of insurance upon request.

(b) When benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves shall be determined in accordance with the Standard Valuation Law. All valuation assumptions used in constructing the reserves shall be determined as appropriate for statutory valuation purposes by a member in good standing of the American Academy of Actuaries. Mortality tables and interest currently recognized for life insurance reserves by the National Association of Insurance Commissioners (NAIC) may be used as well as appropriate assumptions for the other provisions incorporated in the policy form. The actuary must follow both actuarial standards and certification for good and sufficient reserves. Reserves in the aggregate must be sufficient to cover:

(1) policies upon which no claim has yet arisen; and

(2) policies upon which an accelerated claim has arisen.

(c) For policies and certificates that provide actuarially equivalent benefits, no additional reserves need to be established.

(d) Policy liens and policy loans, including accrued interest, represent assets of the company for statutory reporting purposes. For any policy on which the policy lien exceeds the policy's statutory reserve liability, such excess must be held as a nonadmitted asset. *(Department of Insurance; 760 IAC 1-48-11; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1824; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-48-12 Filing; prior approval

Authority: IC 27-1-3-7
Affected: IC 27-1-12

Sec. 12. The filing and prior approval of forms containing an accelerated benefit is required. *(Department of Insurance; 760 IAC 1-48-12; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1824; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 49. Registration of Medical Claims Review Agents

760 IAC 1-49-1 Authority

Authority: IC 27-8-16-14
Affected: IC 27-8-16-14

Sec. 1. This rule is adopted and promulgated by the department of insurance under IC 27-8-16-14. *(Department of Insurance; 760 IAC 1-49-1; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1395; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-49-2 Definitions

Authority: IC 27-8-16-14
Affected: IC 27-8-16

Sec. 2. The definitions in IC 27-8-16 shall apply to all provisions contained in this rule. *(Department of Insurance; 760 IAC 1-49-2; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1395; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-49-3 Certification of medical claims review agents

Authority: IC 27-8-16-14
Affected: IC 4-21.5; IC 27-8-16-11

Sec. 3. (a) An application for certification of a medical claims review agent must be filed with the department of insurance at 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204. Initial applications must be filed on or before February 28, 1993.

(b) The application, and fees as addressed in section 11 of this rule, must be submitted on a medical claims review agent application form that can be obtained from the department of insurance. The application form is adopted by reference and may be obtained from the Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204.

(c) The completed application form shall be accompanied by a summary of the following information:

(1) Procedures established for appeal of an adverse determination. These procedures must comply with section 6 of this rule.

(2) Policies and procedures that ensure that all applicable state and federal laws to protect the confidentiality of medical records are followed. These procedures must comply with section 8 of this rule.

(d) The completed application form shall contain the following information:

(1) A certification that the medical claims review agent will comply with the provisions of IC 27-8-16.

(2) The categories of persons employed to perform medical claims review. Personnel changes within the categories do not constitute a material change in the application.

(3) A description of the hours of operation within the state of Indiana and how the medical claims review agent may be contacted during weekends and holidays. This description must be in compliance with section 7 of this rule.

(4) Representative samples of materials provided by the medical claims review agent or applicant to inform its clients, enrollees, or providers of the requirements of medical claims review.

(5) A certification that the medical claims review agent is in compliance with IC 27-8-16-11.

(e) The medical claims review agent shall report any material changes in the information in the application or renewal form referred to in this section not later than the thirtieth day after the date on which the change takes effect.

(f) The application process shall be as follows:

(1) The department of insurance shall have thirty (30) days after receipt of an application to determine whether the application is complete. In the event that an application is found to be incomplete, the department of insurance will give the applicant written notice of the required information necessary to complete the application. If the application is complete, the applicant will be advised that the application has been received and accepted for review.

(2) The department of insurance shall have sixty (60) days from the date the application is determined to be complete under subdivision (1) to process the application and approve or disapprove it. The department of insurance shall give the applicant written notice of any deficiencies noted as a result of the review conducted under this subdivision.

(3) The department of insurance shall afford the applicant an opportunity for a meeting to discuss any omissions or deficiencies noted.

(4) The applicant must correct the omissions or deficiencies in the application within thirty (30) days of the date of the latest notice of the department of insurance of such omissions or deficiencies. If the applicant fails to do so, the application file will be closed as an incomplete application. The application fee will not be refundable.

(5) The department of insurance shall maintain an application file that shall contain the application, notices of omissions or deficiencies, responses, and any written materials generated by any person who was considered by the department of insurance in evaluating the application.

(g) A medical claims review agent must apply for a certificate renewal every year, not later than June 30. The initial renewal shall be completed by June 30, 1994. A renewal form must be used for this purpose. The renewal fee must be submitted with the

renewal form. The renewal form can be obtained from the department of insurance at the address listed in subsection (a). The completed renewal form and the renewal fee must be submitted to the department of insurance at the address listed in subsection (a). A medical claims review agent may continue to operate under its certificate after a completed renewal application form and the renewal fee have been timely received by the department of insurance until the renewal is finally denied or issued by the department of insurance. If a completed renewal application and fee are not received prior to June 30, the certificate will automatically be canceled, and the medical claims review agent must complete and submit a new application form with the new application fee for another certificate of registration.

(h) If an application or renewal is denied under this section, the applicant or registrant may appeal such denial under the terms of the provisions of IC 4-21.5. A hearing of such appeal shall be conducted within forty-five (45) days from the date the petition for hearing is filed with the commissioner. A decision by the commissioner shall be rendered within sixty (60) days from the date of the hearing.

(i) Applications that are filed on or before February 28, 1993, will be processed on a first in, first out basis by the department of insurance. The time lines set out for processing applications in subsection (f) will not apply to these applications.

(j) Entities that were operating in Indiana as medical claims review agents on or after July 1, 1992, must file the application described in subsections (a) through (d) by February 28, 1993. Those entities may continue to operate as medical claims review agents pending review of the application unless they are advised in writing that the application has been disapproved or closed as an incomplete application as described in subsection (f). No entity may continue to operate after fifteen (15) days from the date of the notice of the denial or closure of the file. *(Department of Insurance; 760 IAC 1-49-3; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1395; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-49-4 General standards of medical claims review

Authority: IC 27-8-16-14
Affected: IC 27-8-16

Sec. 4. The medical claims review, including appeal requirements, shall be conducted in accordance with standards or guidelines developed with input from appropriate health care providers and approved by a physician. The medical claims review shall include the following components:

(1) Written procedures for the following:

(A) Notification to the insurance companies, health maintenance organizations, or other benefit programs of the medical claims review agent's determinations.

(B) Appeal of an adverse determination and a copy of any forms used during the appeal process, as required by section 6 of this rule.

(C) Receiving or redirecting toll free telephone calls during normal business hours and after hour calls, either in person or by recording, and assurance that a toll free number will be maintained forty (40) hours per week during normal business hours, as addressed in section 7 of this rule.

(D) Reviewing, including the following:

(i) Any form used during the review process.

(ii) Time frames that shall be met during the review.

(E) Handling of written complaints by enrollees, patients, or health care providers as addressed in section 9(a) of this rule.

(F) Determining if health care providers utilized by the medical claims review agents are licensed.

(G) Orientation and training of personnel who perform medical claims review.

(H) Assuring that patient-specific information obtained during the process of medical claims review, as addressed in section 8 of this rule, will be:

(i) kept confidential in accordance with applicable federal and state laws;

(ii) used for purposes of medical claims review, quality assurance, discharge planning, and catastrophic case management;

(iii) shared with only those agencies (such as the claims administrator) that have authority to receive such information; and

(iv) summary data shall not be considered confidential if it does not provide sufficient information to allow for

identification of individual patients.

(2) Each medical claims review agent shall utilize written screening criteria and review procedures that are established and periodically evaluated and updated with appropriate involvement from health care providers. Such written screening criteria and review procedures shall be available for review and inspection by the commissioner or a designated department of insurance representative and copying, as necessary, for the commissioner to carry out his or her lawful duties under the Insurance Code, provided; however, that any information obtained or acquired under the authority of this rule and IC 27-8-16 is confidential and privileged and not subject to the open records law or subpoena except to the extent necessary for the commissioner to enforce this rule and IC 27-8-16.

(3) Medical claims review agents' decisions shall be made in accordance with standards or guidelines that are developed with input from appropriate health care providers and approved by a physician.

(Department of Insurance; 760 IAC 1-49-4; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1397; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-49-5 Notice of determinations made by medical claims review agents

Authority: IC 27-8-16-14
Affected: IC 27-8-16-7

Sec. 5. In making a determination as to reimbursement of a claim, medical claims review agents shall comply with all provisions contained in IC 27-8-16-7. *(Department of Insurance; 760 IAC 1-49-5; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1397; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-49-6 Appeal of adverse determination of medical claims review agents

Authority: IC 27-8-16-14
Affected: IC 27-8-16-8

Sec. 6. A medical claims review agent shall comply with all provisions of IC 27-8-16-8 in establishing an appeal procedure for adverse determinations. *(Department of Insurance; 760 IAC 1-49-6; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1397; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-49-7 Medical claims review agent's telephone access

Authority: IC 27-8-16-14
Affected: IC 27-8-16-7

Sec. 7. (a) A medical claims review agent shall have personnel available by toll free telephone at least forty (40) hours per week during normal business hours.

(b) A medical claims review agent must have a telephone system capable of accepting, recording, or providing instructions to incoming calls during other than normal business hours and shall respond to such calls not later than two (2) working days after the date on which the call was received. *(Department of Insurance; 760 IAC 1-49-7; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1397; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-49-8 Confidentiality

Authority: IC 27-8-16-14
Affected: IC 27-8-16

Sec. 8. (a) A medical claims review agent shall preserve the confidentiality of individual medical records to the extent required by state and federal laws.

(b) To assure confidentiality, a medical claims review agent must, when contacting a health care provider's office or hospital, provide its certification number and the caller's name to the provider's named claim review agent representative in the health care provider's office.

(c) Medical records and patient-specific information shall be maintained by the medical claims review agent in a secure area

with access limited to medical claims review personnel only.

(d) Information generated and obtained by the medical claims review agent or employer of the medical claims review agent in the course of medical claims review shall be retained for at least two (2) years if the information relates to a case for which an adverse decision was made at any point or if the information relates to a case that may be reopened. *(Department of Insurance; 760 IAC 1-49-8; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1398; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-49-9 Complaints and information

Authority: IC 27-8-16-14
Affected: IC 27-8-16

Sec. 9. (a) Within a reasonable time period, upon receipt of a written complaint alleging a violation of this section or IC 27-8-16 by a medical claims review agent, from an enrollee's health care provider, a person acting on behalf of the enrollee, or the enrollee, the commissioner or a designated department of insurance representative shall investigate the complaint and furnish a written response to the complainant and the medical claims review agent named. The response will not identify in any manner the patient or patients without written consent. This response must include the following:

(1) A statement of the original complaint.

(2) A copy of any written response by the medical claims review agent. The written response should not contain privileged medical records. If it is necessary to refer to medical records, they shall be forwarded separate from the response and clearly marked as privileged medical records.

(3) A statement of the findings of the commissioner or a designated department of insurance representative and an explanation of the basis of such findings.

(4) Corrective actions, if any, on the part of the medical claims review agent that the commissioner or a designated department of insurance representative finds appropriate.

(5) A time frame in which any corrective actions should be completed. The medical claims review agent will provide evidence of corrective action within the specified time frame to the commissioner or a designated department of insurance representative.

(b) In addition to the authority of the commissioner to respond to complaints described in subsection (a), the department of insurance is authorized to address inquiries to medical claims review agents that the department of insurance may deem necessary for the public good or for a proper discharge of its duties. It shall be the duty of the agent to promptly answer such inquiries in writing.

(c) The commissioner shall maintain and update a list of medical claims review agents issued certificates, including certificate numbers and the renewal date for those certificates. The commissioner shall provide the list at cost to all individuals or organizations requesting the list.

(d) Requirements for on-site review by the department of insurance shall be as follows:

(1) The commissioner or a designated department of insurance representative is authorized to make a complete on-site review of the operations of each medical claims review agent at the principal place of business for such agent as often as is deemed necessary.

(2) Medical claims review agents will be notified of the scheduled on-site visit by letter which will specify, as a minimum, the identity of the commissioner's designated department of insurance representative and the expected arrival date and time.

(3) The medical claims review agent must make available during such on-site visits all records relating to its operation.

(4) The commissioner or the designated department of insurance representative may perform periodic telephone audits of medical claims review agents authorized to conduct business in this state to determine if the agents are reasonably accessible.

(Department of Insurance; 760 IAC 1-49-9; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1398; errata filed Feb 10, 1993, 4:00 p.m.: 16 IR 1514; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-49-10 Administrative violations

Authority: IC 27-8-16-14
Affected: IC 27-8-16-12

Sec. 10. If the commissioner, through the commissioner's designated representative, believes that a medical claims review

agent may have violated, or is violating, this section or IC 27-8-16, the commissioner's designated representative shall comply with IC 27-8-16-12 in investigating the complaint and, where appropriate, in imposing sanctions against the medical claims review agent. *(Department of Insurance; 760 IAC 1-49-10; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1398; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-49-11 Fees

Authority: IC 27-8-16-5; IC 27-8-16-6; IC 27-8-16-14
Affected: IC 27-8-16-5; IC 27-8-16-6

Sec. 11. (a) The fee for initial application for certification as a medical claims review agent is one hundred fifty dollars ($150) and must accompany the application.

(b) The annual renewal fee for a certificate as a medical claims review agent is one hundred dollars ($100) and must accompany the application. The annual renewal fee is nonrefundable. *(Department of Insurance; 760 IAC 1-49-11; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1399; filed Sep 5, 1996, 11:00 a.m.: 20 IR 16; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 50. Continuing Education

760 IAC 1-50-1 Authority (Expired)

Sec. 1. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

760 IAC 1-50-2 Definitions

Authority: IC 27-1-15.7-7
Affected: IC 27-1-15.6-2; IC 27-1-15.7-2; IC 27-1-15.7-6

Sec. 2. In addition to the definitions in IC 27-1-15.6-2, the following definitions apply throughout this rule:

(1) "Advisory council" means the insurance producer education and continuing education advisory council created by IC 27-1-15.7-6.

(2) "Department" means the department of insurance.

(3) "Producer" means an insurance producer as defined by IC 27-1-15.6-2(7) and shall also include a solicitor licensed under IC 27-1-15.6-2(7).

(4) "Provider" means an individual, insurance company, insurance trade association, accredited college, or insurance education institution that offers an insurance producer continuing education course that is approved by the commissioner.

(Department of Insurance; 760 IAC 1-50-2; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1825; filed Nov 4, 1999, 10:12 a.m.: 23 IR 572; filed Dec 12, 2003, 10:30 a.m.: 27 IR 1568)

760 IAC 1-50-3 Continuing education credit hour defined

Authority: IC 27-1-15.7-4; IC 27-1-15.7-7
Affected: IC 27-1-15.7-2

Sec. 3. (a) A continuing education credit hour is based on a one (1) hour block of time. Fifty (50) minutes of instruction in a sixty (60) minute period will constitute one (1) continuing education credit hour. Time designated by the provider as break time may not be considered when computing course credit hours.

(b) Continuing education credit hours will be approved in no less than one-half (½) hour increments.

(c) Except as provided in section 4(h) of this rule, two (2) continuing education credit hours are the minimum number of hours that will be approved for a continuing education course.

(d) Eight (8) hours of classroom instruction per day are the maximum number of hours that will be approved for a continuing education course. *(Department of Insurance; 760 IAC 1-50-3; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1825; filed Nov 4, 1999, 10:12 a.m.: 23 IR 573; filed Dec 12, 2003, 10:30 a.m.: 27 IR 1569)*

760 IAC 1-50-4 Application requirements

Authority: IC 27-1-15.7-4; IC 27-1-15.7-7
Affected: IC 27-1-15.7-2

Sec. 4. (a) Any individual, insurance company, insurance trade association, insurance producer association, accredited college, or insurance education institution may submit continuing education courses for approval by the commissioner.

(b) Course information must be submitted on an application form that may be obtained from the Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204-2787. The application form is adopted by reference.

(c) A completed application form shall be submitted to the Continuing Education Program, c/o Indiana Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204-2787.

(d) The application form shall be submitted at least sixty (60) days prior to the date of the continuing education course.

(e) A provider may advertise a continuing education course after submission to the department but before its approval; however, the provider must clearly indicate in any advertisement of the course that course approval is pending.

(f) A nonrefundable processing fee in the amount of forty dollars ($40) per course, or a yearly fee in the amount of five hundred dollars ($500) for all courses, shall be submitted to the department along with a completed application form.

(g) Videotaped, Internet, and satellite broadcast programs may be approved for continuing education credit.

(h) Each educational segment within a convention program or an association annual meeting shall be submitted individually for continuing education credit. Notwithstanding section 3(b) of this rule, the educational segment may be approved for one (1) hour of credit.

(i) Applications for continuing education course approval shall be presented to the advisory council. The advisory council shall review each application and make a recommendation to the commissioner on whether the course should be approved and the number of credit hours to be awarded. The department shall notify the provider in writing when the commissioner approves or disapproves a continuing education course.

(j) Course approval is valid for two (2) years from the date of the commissioner's approval. Thereafter, the course must be resubmitted for approval under this section. *(Department of Insurance; 760 IAC 1-50-4; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1825; filed Nov 4, 1999, 10:12 a.m.: 23 IR 573; filed Dec 12, 2003, 10:30 a.m.: 27 IR 1569)*

760 IAC 1-50-5 Requirements for self-study continuing education courses

Authority: IC 27-1-15.7-4; IC 27-1-15.7-7
Affected: IC 27-1-15.6-12; IC 27-1-15.7-4

Sec. 5. (a) In addition to the requirements in section 4 of this rule, self-study courses are subject to the following requirements:

(1) A producer enrolled in a self-study course, including a computer-based course, shall take a written or computer-based examination at the conclusion of the self-study course. The written or computer-based examination must comply with the following requirements:

(A) Examination questions shall be multiple choice.

(B) Questions shall be selected at random from a bank of questions.

(C) At least three (3) different versions of the examination shall be used on a random basis.

(D) The examination for a course approved for eight (8) hours of credit or less shall consist of at least twenty-five (25) questions.

(E) The examination for a course approved for greater than eight (8) hours of credit shall consist of at least fifty (50) questions.

(F) The written examination shall be sealed in an opaque envelope. The testing protocol and affidavit requirements of subdivision (4) shall be written on the outside of the envelope.

(G) The examination shall be graded by the provider.

(H) A computer-based examination may not include prompts designed to aid the student in answering examination questions.

(2) A producer must correctly answer seventy percent (70%) of the examination questions in order to pass the self-study course.

(3) A producer must pass a self-study examination to receive any continuing education credit hours for the self-study course.

(4) When taking the self-study examination, the producer shall sign an affidavit, supplied by the provider, that states the producer did not use outside help, such as an open textbook or another individual, in taking the examination. A second producer must sign the affidavit verifying that the second producer witnessed the first producer's examination and no outside help was used. The signed affidavit must be returned to the provider. The provider shall retain the original affidavit for four (4) years.

(5) The provider shall grade the examination and mail the results to the producer no later than thirteen (13) days after the date upon which the producer mailed the completed examination to the provider.

(6) A computer-based course that includes a computer-based examination must be designed to prevent the student from skipping the education materials before taking the examination.

(b) Failure to comply with the requirements of this section may result in disciplinary action by the department under IC 27-1-15.6-12. *(Department of Insurance; 760 IAC 1-50-5; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1826; filed Nov 4, 1999, 10:12 a.m.: 23 IR 574; filed Dec 12, 2003, 10:30 a.m.: 27 IR 1569)*

760 IAC 1-50-6 Appeals of continuing education courses

Authority: IC 27-1-15.5-7.1
Affected: IC 27-1-15.5-7.1

Sec. 6. (a) In the event a provider objects to the number of hours assigned to a continuing education course or the commissioner disapproves a course, the provider may appeal the commissioner's decision. The appeal shall be made in writing to the commissioner within thirty (30) days after the commissioner's decision.

(b) The commissioner, in consultation with the advisory council, shall consider any appeal filed by a provider.

(c) The decision of the commissioner shall be a final administrative order. *(Department of Insurance; 760 IAC 1-50-6; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1826; filed Nov 4, 1999, 10:12 a.m.: 23 IR 574)*

760 IAC 1-50-7 Record keeping requirements

Authority: IC 27-1-15.7-7
Affected: IC 27-1-15.7-4

Sec. 7. (a) A provider shall take attendance at each continuing education course. The provider shall retain the attendance reports for four (4) years. The attendance report shall contain the following information:

(1) The producer's name.

(2) The producer's license number.

(3) The producer's birth date.

(4) The producer's signature.

(5) Any other information requested by the department.

(b) A provider shall provide each producer who attends a continuing education course, or passes a self-study course, with a certificate of completion form no later than ten (10) days following the completion of the course. The certificate of completion form is adopted by reference, and a copy of the form may be obtained from the Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204-2787.

(c) For two (2) years following a continuing education course, the provider shall prepare a duplicate certificate of completion upon the request of a producer who attended the course. The certificate must be provided within ten (10) days of the request.

(d) No later than ten (10) days after a request from the department, the provider shall deliver to the department a list of the producers to whom it has delivered a certificate of completion for a specific course or courses.

(e) In the event a provider fails to provide a certificate of completion as required in this section, the commissioner may suspend approval of any or all of a provider's continuing education courses.

(f) The producer shall retain the certificate of completion for four (4) years following completion of the course.

(g) A provider shall notify the department at least thirty (30) days in advance of an approved continuing education course being offered. *(Department of Insurance; 760 IAC 1-50-7; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1826; filed Nov 4, 1999, 10:12 a.m.: 23 IR 575; errata filed Dec 15, 1999, 9:08 a.m.: 23 IR 1110; filed Dec 12, 2003, 10:30 a.m.: 27 IR 1570)*

760 IAC 1-50-8 Agent record keeping responsibilities (Repealed)

Sec. 8. *(Repealed by Department of Insurance; filed Nov 4, 1999, 10:12 a.m.: 23 IR 577)*

760 IAC 1-50-9 Solicitor's continuing education requirements

Authority: IC 27-1-15.5-7.1
Affected: IC 27-1-15.5-7.3; IC 27-1-15.5-7.7

Sec. 9. Beginning with the January 1993 renewals, and each year thereafter, individuals renewing their solicitor's license must show proof of having completed fifteen (15) hours of continuing education credit each year. *(Department of Insurance; 760 IAC 1-50-9; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1827; filed Nov 4, 1999, 10:12 a.m.: 23 IR 575)*

760 IAC 1-50-10 Reciprocal agreements

Authority: IC 27-1-15.5-7.1
Affected: IC 27-1-15.5-7.3

Sec. 10. (a) The department may enter into reciprocal agreements with other states for the approval or disapproval of continuing education courses. When considering an application for continuing education course approval, the department shall approve a continuing education course approved by a state that has entered into a reciprocal agreement with the department for the same number of credit hours it was approved for in the other state.

(b) Notwithstanding subsection (a), no course described in IC 27-1-15.5-7.3(b) shall be approved under this section. *(Department of Insurance; 760 IAC 1-50-10; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1828; filed Nov 4, 1999, 10:12 a.m.: 23 IR 576)*

760 IAC 1-50-11 List of continuing education course providers

Authority: IC 27-1-15.5-7.1
Affected: IC 27-1-15.5-7.1

Sec. 11. The department shall maintain a current list of providers who offer approved continuing education courses. *(Department of Insurance; 760 IAC 1-50-11; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1828; filed Nov 4, 1999, 10:12 a.m.: 23 IR 576)*

760 IAC 1-50-12 Extension of continuing education course requirements (Repealed)

Sec. 12. *(Repealed by Department of Insurance; filed Nov 4, 1999, 10:12 a.m.: 23 IR 577)*

760 IAC 1-50-13 Retirement exemption

Authority: IC 27-1-15.7-7
Affected: IC 27-1-15.6-12

Sec. 13. (a) A retired producer who is required by an insurer to maintain his or her license in order to collect commissions on business written before retirement may apply for an exemption from continuing education requirements.

(b) To obtain a retirement exemption, a producer shall complete and submit to the department the exemption form set forth in section 13.5 of this rule.

(c) The producer shall notify the department of any changes in his or her retirement status.

(d) A retired producer who solicits or services a policy is not eligible to apply for or retain an exemption from the continuing education requirements.

(e) A producer who fails to notify the department of any change in status under this section will be subject to administrative action under IC 27-1-15.6-12. *(Department of Insurance; 760 IAC 1-50-13; filed Feb 23, 1993, 5:00 p.m.: 16 IR 1828; filed Nov 4, 1999, 10:12 a.m.: 23 IR 576; filed Dec 12, 2003, 10:30 a.m.: 27 IR 1570)*

760 IAC 1-50-13.5 Retirement exemption form

Authority: IC 27-1-15.7-7
Affected: IC 27-1-15.6-3; IC 27-1-15.7-2

Sec. 13.5. The form referenced in section 13 of this rule is as follows:

CONTINUING EDUCATION EXEMPTION FORM
FOR RETIRED INSURANCE PRODUCERS
AND SOLICITORS

I, _____, do hereby attest that effective _____ I am retired and am no longer an active insurance producer. I will not solicit or service any insurance policy or policyholder. I respectfully request that I be exempt from fulfilling the continuing education requirements as prescribed by IC 27-1-15.7-2.

If my current situation changes and I plan to solicit or service insurance policies or policyholders, I will immediately notify the Indiana Department of Insurance of my change in status. I understand that the Department will rescind any continuing education exemption, and I will thereafter be responsible for all continuing education requirements as prescribed in IC 27-1-15.7-2.

I further understand that if I fail to notify the Department of Insurance of any change in my retirement status and I engage in the business of insurance, including soliciting or servicing an insurance policy, I will be subject to administrative sanctions.

Date	Signature
License number	Address
License expiration date	City/State Zip

Subscribed and sworn to before me this _____ day of _____, ____

_____
Notary Public
My commission expires: _____
County of residence: _____

(Department of Insurance; 760 IAC 1-50-13.5; filed Nov 4, 1999, 10:12 a.m.: 23 IR 576; filed Dec 12, 2003, 10:30 a.m.: 27 IR 1571)

760 IAC 1-50-14 Disciplinary sanctions (Repealed)

Sec. 14. *(Repealed by Department of Insurance; filed Nov 4, 1999, 10:12 a.m.: 23 IR 577)*

760 IAC 1-50-15 Fees (Repealed)

Sec. 15. *(Repealed by Department of Insurance; filed Nov 4, 1999, 10:12 a.m.: 23 IR 577)*

Rule 51. Procedures for Reinsurance Intermediaries

760 IAC 1-51-1 Authority

Authority: IC 27-6-9-26
Affected: IC 27-6-9-26

Sec. 1. This rule is adopted and promulgated by the department of insurance under IC 27-6-9-26. *(Department of Insurance; 760 IAC 1-51-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2561; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-51-2 Definitions

Authority: IC 27-6-9-26
Affected: IC 27-6-9

Sec. 2. (a) The definitions as set forth in IC 27-6-9 shall apply for purposes of this rule, in addition to the definition in this section.

(b) As used in this rule, "annual reinsurance premium" means all reinsurance premiums managed by a reinsurance intermediary regardless of where the risks are located. *(Department of Insurance; 760 IAC 1-51-2; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2561; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-51-3 Licensing requirements

Authority: IC 27-6-9-26
Affected: IC 27-6-9

Sec. 3. (a) The initial licensing form for a reinsurance intermediary must be filed with the department of insurance on or before July 1, 1993, and will be subject to renewal annually on or before July 1 of each year thereafter.

(b) The application form to license a reinsurance intermediary can be obtained from the department of insurance. The application form is adopted by reference, and a copy may be obtained from the Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204-2787.

(c) A nonrefundable application fee of one hundred dollars ($100), payable by either check or money order, must accompany the application form.

(d) If the applicant, and all persons whose names are listed as reinsurance intermediary on the application, meet the qualifications of IC 27-6-9, the department of insurance will issue the applicant a reinsurance intermediary license.

(e) Any person, firm, association, or corporation who is required to obtain a reinsurance intermediary license and who is not a resident of this state must obtain a nonresident reinsurance intermediary license.

(f) The reinsurance intermediary shall report any material changes in the information in the application or renewal form referred to in this section not later than thirty (30) days after the date on which the change takes effect.

(g) The application process shall be as follows:

(1) The department of insurance shall have thirty (30) days after receipt of an application to determine whether the application is complete. In the event that an application is found to be incomplete, the department of insurance will give the applicant written notice of the required information necessary to complete the application. If the application is complete, the applicant will be advised that the application has been received and accepted for review.

(2) The department of insurance shall have sixty (60) days from the date the application is determined to be complete under subdivision (1) to process the application and to approve or disapprove it. The department of insurance shall give the applicant written notice of any deficiencies noted as a result of the review conducted under this subdivision. If approved, the department shall give the applicant written notice of the approval.

(3) The department of insurance shall afford the applicant an opportunity for a meeting to discuss any omissions or deficiencies noted.

(4) The applicant must correct the omissions or deficiencies in the application within thirty (30) days of the date of the latest notice of the department of insurance of such omissions or deficiencies. If the applicant fails to do so, the application file will be closed as an incomplete application. The application fee will not be refundable.

(5) The department of insurance shall maintain an application file which shall contain the application, notices of any omissions or deficiencies, responses, and any written materials generated by any person who was considered by the department of insurance in evaluating the application.

(h) The renewal process shall be as follows:

(1) A reinsurance intermediary license is valid for one (1) year from the date of issuance. A reinsurance intermediary shall apply for a license renewal every year on or before the anniversary date of issuance or the license shall terminate.

(2) The renewal form can be obtained from the commissioner of the department of insurance at the address listed in subsection (b).

(3) A completed renewal form and a renewal application fee of one hundred dollars ($100) must be submitted to the

commissioner of the department of insurance at the address listed in subsection (b).

(4) A reinsurance intermediary may continue to operate under its license after a completed renewal application form and the renewal fee have been timely received by the department of insurance until the renewal is finally denied by the department of insurance.

(Department of Insurance; 760 IAC 1-51-3; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2561; filed Sep 5, 1996, 11:00 a.m.: 20 IR 16; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-51-4 Fidelity bond requirement

Authority: IC 27-6-9-26
Affected: IC 27-6-9-14

Sec. 4. (a) All reinsurance intermediary-managers shall acquire and maintain a fidelity bond for the protection of the reinsurer contracting with the reinsurance intermediary-manager.

(b) The bond shall be in an amount equal to five hundred thousand dollars ($500,000) or ten percent (10%) of the annual reinsurance premium managed by the reinsurance intermediary-manager, whichever is greater, except that mandatory bond limits under this subsection shall not exceed ten million dollars ($10,000,000).

(c) The bond amount shall be adjusted accordingly on or before the license renewal of the reinsurance intermediary-manager each year.

(d) A copy of the executed bond shall be filed with the commissioner of the department of insurance at the time the initial license application is filed.

(e) The insurer shall provide the department with appropriate documentation to show that the bond continues in force or that a new bond has been secured at each renewal. *(Department of Insurance; 760 IAC 1-51-4; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2562; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-51-5 Errors and omissions policy requirement

Authority: IC 27-6-9-26
Affected: IC 27-6-9-14

Sec. 5. (a) All reinsurance intermediary-managers shall acquire and maintain an errors and omissions insurance policy with limits equal to those specified in subsection (b).

(b) The policy coverage limits shall be two hundred fifty thousand dollars ($250,000) or twenty-five percent (25%) of the annual reinsurance premium managed by the reinsurance intermediary-manager, whichever is greater, except that mandatory policy limits under this subsection shall not exceed ten million dollars ($10,000,000).

(c) The policy limits shall be adjusted accordingly on or before the license renewal of the reinsurance intermediary-manager each year.

(d) Proof of such insurance shall be filed with the commissioner of the department of insurance at the time of the initial license application.

(e) The insurer shall provide the department of insurance with appropriate documentation to show that the errors and omissions policy remains in force or that a new policy has been secured at each renewal. *(Department of Insurance; 760 IAC 1-51-5; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2562; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-51-6 Compilation and review

Authority: IC 27-6-9-26
Affected: IC 27-6-9

Sec. 6. (a) The reinsurance intermediary-manager shall contract with a certified public accountant for an annual compilation and review. The compilation shall include the following:

(1) A report by an independent certified public accountant.

(2) A balance sheet.

(3) A statement of income.

(4) A statement of cash flows.

(5) A statement of income and retained earnings.

(6) Verification by management, under oath, of the amount of reinsurance premiums written for the previous calendar year.

(b) The insurer shall retain a copy of the compilation and review conducted under subsection (a) for each reinsurance intermediary-manager with whom the insurer has a contract.

(c) The department of insurance shall retain authority to examine a reinsurance intermediary-manager notwithstanding termination of the reinsurance intermediary-manager's contractual authority. *(Department of Insurance; 760 IAC 1-51-6; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2562; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-51-7 Separability

Authority: IC 27-6-9-26
Affected: IC 27-6-9

Sec. 7. If any provision of this rule or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby. *(Department of Insurance; 760 IAC 1-51-7; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2563; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 52. Managing General Agents; Procedures

760 IAC 1-52-1 Authority

Authority: IC 27-1-33-11
Affected: IC 27-1-33-11

Sec. 1. This rule is adopted and promulgated by the department of insurance under IC 27-1-33-11. *(Department of Insurance; 760 IAC 1-52-1; filed Feb 4, 1994, 5:00 p.m.: 17 IR 1090; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-52-2 Definitions

Authority: IC 27-1-33-11
Affected: IC 27-1-33-4

Sec. 2. (a) The definitions contained in IC 27-1-33, in addition to the definitions in this section, shall apply for purposes of this rule.

(b) A person, firm, association, or corporation shall qualify as a managing general agent under IC 27-1-33-4(a)(4)(A) only if the person, firm, association, or corporation, in addition to other criteria set forth in IC 27-1-33-4, has the authority to adjust or pay claims in an amount equal to or exceeding fifteen thousand dollars ($15,000) per claim.

(c) As used in this rule, “gross direct written premium” means all direct premiums written by a managing general agent regardless of where the risks are located. *(Department of Insurance; 760 IAC 1-52-2; filed Feb 4, 1994, 5:00 p.m.: 17 IR 1090; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-52-3 Registration of managing general agents

Authority: IC 27-1-33-11
Affected: IC 27-1-33-7

Sec. 3. (a) The initial registration form for managing general agents must be filed with the department of insurance by each insurer who contracts with a managing general agent on or before March 1, 1994, and will be subject to renewal on July 1, 1995, and annually each July 1 thereafter.

(b) The form to register managing general agents can be obtained from the department of insurance. The registration form is adopted by reference, and a copy may be obtained from the Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204-2787.

(c) A nonrefundable fee of one hundred dollars ($100), payable by either check or money order, must accompany the registration form.

(d) At the time of filing with the department of insurance the initial registration form for managing general agents described in subsections (a) and (b), each insurer must file with the department of insurance a sample contract agreement between itself and a managing general agent as described in IC 27-1-33-7.

(e) Subsequent to the initial registration of managing general agents, any insurer which enters into a contract with any person, firm, association, or corporation meeting the definition of a managing general agent shall be required to register that managing general agent with the commissioner of the department of insurance within thirty (30) days of entering into such contract. Such registration is required on the form described in subsection (b).

(f) Subsequent to the initial registration of managing general agents, any insurer which terminates a contract with any person, firm, association, or corporation meeting the definition of a managing general agent shall be required to notify the commissioner of the department of insurance of the termination of that contract within thirty (30) days from the effective date of termination. Such notice is required on the registration form described in subsection (b).

(g) The registration process shall be as follows:

(1) The department of insurance shall have thirty (30) days after receipt of a registration form to determine whether the registration form is complete. In the event that a registration form is found to be incomplete, the department of insurance will give the insurer written notice of the required information necessary to complete the registration form. If the registration form is complete, the insurer will be advised that the registration form has been received and accepted for review.

(2) The department of insurance shall have sixty (60) days from the date that the registration form is determined to be complete under subdivision (1) to process the registration form and to approve or disapprove it. The department of insurance shall give the insurer written notice of any deficiencies noted as a result of the review conducted under this subdivision. If approved, the department of insurance shall give the insurer written notice of the approval.

(3) The department of insurance shall afford the insurer an opportunity for a meeting to discuss any omissions or deficiencies noted.

(4) The insurer must correct the omissions or deficiencies in the registration form within thirty (30) days of the date of the latest notice of the department of insurance of such omissions or deficiencies. If the insurer fails to do so, the registration form file will be closed as an incomplete registration. The registration fee is not refundable.

(5) The department of insurance shall maintain a registration form file which shall contain the registration form, notices of any omissions or deficiencies, responses, and any written materials generated by any person who was considered by the department of insurance in evaluating the registration form.

(h) The renewal process shall be as follows:

(1) Subject to subsection (a), a managing general agent registration is valid for one (1) year from the date of issuance. An insurer shall apply for a registration renewal each July 1 after the date of issuance or the registration shall terminate.

(2) The registration renewal form can be obtained from the commissioner of the department of insurance at the address listed in subsection (b).

(3) A completed registration renewal form and a renewal fee of one hundred dollars ($100) must be submitted to the commissioner of the department of insurance at the address listed in subsection (b).

(4) After a completed registration renewal form and the renewal fee have been timely received by the department of insurance, a managing general agent may continue to operate under its registration until the registration renewal is denied by the department of insurance.

(Department of Insurance; 760 IAC 1-52-3; filed Feb 4, 1994, 5:00 p.m.: 17 IR 1091; filed Sep 5, 1996, 11:00 a.m.: 20 IR 17; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-52-4 Fidelity bond requirement

Authority: IC 27-1-33-11
Affected: IC 27-1-33-6

Sec. 4. (a) Every registered managing general agent shall acquire and maintain a fidelity bond for the protection of the insurer contracting with the managing general agent.

(b) The bond shall be in an amount equal to ten percent (10%) of the gross direct written premium that is attributable to the

managing general agent, except that the bond shall be no less than one hundred thousand dollars ($100,000) and no more than five hundred thousand dollars ($500,000).

(c) The bond amount shall be adjusted accordingly on or before July 1 of each year.

(d) A copy of the executed bond shall be filed with the commissioner of the department of insurance by the insurer on behalf of the managing general agent at the time of the initial registration of the managing general agent.

(e) The insurer shall provide the department of insurance with appropriate documentation to show that the bond continues in force or that a new bond has been secured at each renewal. *(Department of Insurance; 760 IAC 1-52-4; filed Feb 4, 1994, 5:00 p.m.: 17 IR 1092; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-52-5 Errors and omissions policy requirement

Authority: IC 27-1-33-11
Affected: IC 27-1-33-6

Sec. 5. (a) All registered managing general agents shall acquire and maintain an errors and omissions insurance policy with limits equal to those specified in subsection (b).

(b) The policy coverage limits shall be two hundred fifty thousand dollars ($250,000) or twenty-five percent (25%) of the gross direct written premium that is attributable to the managing general agent, whichever is greater, except that the policy limit shall not exceed ten million dollars ($10,000,000).

(c) The policy coverage limits shall be adjusted accordingly on or before July 1 of each year.

(d) Proof of insurance shall be filed with the commissioner of the department of insurance by the insurer on behalf of the managing general agent at the time of the initial registration of the managing general agent.

(e) The insurer shall provide the department of insurance with appropriate documentation to show that the errors and omissions policy remains in force or that a new policy has been secured at each renewal. *(Department of Insurance; 760 IAC 1-52-5; filed Feb 4, 1994, 5:00 p.m.: 17 IR 1092; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-52-6 Annual compilation

Authority: IC 27-1-33-11
Affected: IC 27-1-33-8; IC 27-1-33-9

Sec. 6. (a) The insurer shall contract with a certified public accountant for an annual compilation of each managing general agent with which it contracts. The compilation shall include the following:

(1) A report by an independent certified public accountant.

(2) A balance sheet.

(3) A statement of income.

(4) A statement of cash flows.

(5) A statement of income and retained earnings.

(6) Verification by the management of the insurer, under oath, of the amount of gross direct written premium for the previous calendar year.

(b) The insurer shall retain a copy of the annual compilation conducted under subsection (a) for each managing general agent with whom the insurer has a contract.

(c) The department of insurance may accept an audit prepared by a certified public accountant in place of the compilation.

(d) A managing general agent may be examined by the department of insurance as if it were an insurer, and the managing general agent shall bear the costs of any such examination.

(e) The department of insurance shall retain authority to examine a managing general agent notwithstanding termination of the managing general agent's contractual authority with an insurer. *(Department of Insurance; 760 IAC 1-52-6; filed Feb 4, 1994, 5:00 p.m.: 17 IR 1092; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-52-7 Separability

Authority: IC 27-1-33-11
Affected: IC 27-1-33

Sec. 7. If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby. *(Department of Insurance; 760 IAC 1-52-7; filed Feb 4, 1994, 5:00 p.m.: 17 IR 1092; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 53. Standards for Companies Deemed to be in Hazardous Financial Condition

760 IAC 1-53-1 Authority

Authority: IC 27-1-3-7
Affected: IC 27-1-1-1

Sec. 1. This rule is adopted and promulgated by the department of insurance under IC 27-1-3-7. *(Department of Insurance; 760 IAC 1-53-1; filed Aug 24, 1993, 5:00 p.m.: 17 IR 8; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-53-2 Purpose

Authority: IC 27-1-3-7
Affected: IC 27-1-1-1

Sec. 2. (a) This rule sets forth standards which may be used by the commissioner of the department of insurance to identify and to correct insurers found to be in such condition as to render the continuance of their business hazardous to the public or to holders of their policies or certificates of insurance.

(b) This rule shall not be interpreted to limit the powers granted to the commissioner of the department of insurance by any laws or parts of laws of this state, nor shall this rule be interpreted to supersede any laws or parts of laws of this state. *(Department of Insurance; 760 IAC 1-53-2; filed Aug 24, 1993, 5:00 p.m.: 17 IR 8; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-53-3 Standards

Authority: IC 27-1-3-7
Affected: IC 27-1-1-1

Sec. 3. The following standards, either singly or a combination of two (2) or more, may be considered by the commissioner of the department of insurance to determine whether the continued operation of any insurer transacting insurance business in this state might be deemed to be hazardous to the policyholders, creditors, or general public. The commissioner of the department of insurance may consider the following:

(1) Adverse findings reported in financial condition and market conduct examination reports.

(2) The National Association of Insurance Commissioners Insurance Regulatory Information System and its related reports.

(3) The ratios of commission expense, general insurance expense, policy benefits, and reserve increases as to annual premium and net investment income which could lead to an impairment of capital and surplus.

(4) Whether the insurer's asset portfolio when viewed in light of current economic conditions is of sufficient value, liquidity, or diversity to assure the company's ability to meet its outstanding obligations as they mature.

(5) The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the company's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer.

(6) Whether the insurer's operating loss in the last twelve (12) month period or any shorter period of time, including, but not limited to:

(A) net capital gain or loss;
(B) change in nonadmitted assets; and
(C) cash dividends paid to shareholders;

is greater than fifty percent (50%) of the insurer's remaining surplus as regards policyholders in excess of the minimum required.

(7) Whether any affiliate, subsidiary, or reinsurer is insolvent, threatened with insolvency, or delinquent in payment of its

monetary or other obligations.

(8) Contingent liabilities, pledges, or guaranties which either individually or collectively involve a total amount which, in the opinion of the commissioner of the department of insurance, may affect the solvency of the insurer.

(9) Whether any controlling person of an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer.

(10) The age and collectibility of receivables.

(11) Whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of the insurer, fails to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in such position.

(12) Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry.

(13) Whether management of an insurer has filed any false or misleading sworn financial statement or has released a false or misleading financial statement to lending institutions or the general public.

(14) Whether management of an insurer has made a false or misleading entry or has omitted an entry of material amount in the books of the insurer.

(15) Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner.

(16) Whether the company has experienced or will experience in the foreseeable future cash flow and/or liquidity problems.

(Department of Insurance; 760 IAC 1-53-3; filed Aug 24, 1993, 5:00 p.m.: 17 IR 8; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-53-4 Authority of the commissioner of the department of insurance

Authority: IC 27-1-3-7
Affected: IC 27-1-1-1

Sec. 4. For the purpose of making a determination of an insurer's financial condition under this rule, the commissioner of the department of insurance may:

(1) disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired, or otherwise subject to a delinquency proceeding;

(2) make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates;

(3) refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; and

(4) increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next twelve (12) month period.

(Department of Insurance; 760 IAC 1-53-4; filed Aug 24, 1993, 5:00 p.m.: 17 IR 9; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-53-5 Order of the commissioner of the department of insurance

Authority: IC 27-1-3-7
Affected: IC 4-21.5-4-4; IC 27-1-1-1; IC 27-9-2-1

Sec. 5. (a) If the commissioner of the department of insurance determines that the continued operation of the insurer licensed to transact business in this state may be hazardous to the policyholders or the general public, then the commissioner of the department of insurance may, in addition to any other action the commissioner of the department of insurance may take under IC 27-9-2-1(b) or any other statute or rule, issue an order requiring the insurer to do the following:

(1) Reduce the total amount of present and potential liability for policy benefits by reinsurance.

(2) Reduce, suspend, or limit the volume of business being accepted or renewed.

(3) Reduce general insurance and commission expenses by specified methods.

(4) Increase the insurer's capital and surplus.

(5) Suspend or limit the declaration and payment of dividends by an insurer to its stockholders or to its policyholders.

(6) File reports in a form acceptable to the commissioner of the department of insurance concerning the market value of an insurer's assets.

(7) Limit or withdraw from certain investments or discontinue certain investment practices to the extent the commissioner of the department of insurance deems necessary.

(8) Document the adequacy of premium rates in relation to the risks insured.

(9) File, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or in such format as promulgated by the commissioner of the department of insurance.

If the insurer is a foreign insurer, the order of the commissioner of the department of insurance may be limited to the extent provided by statute.

(b) Any insurer subject to an order under subsection (a) may request a hearing to review that order as permitted under IC 4-21.5-4-4. *(Department of Insurance; 760 IAC 1-53-5; filed Aug 24, 1993, 5:00 p.m.: 17 IR 9; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-53-6 Review of order

Authority: IC 27-1-3-7
Affected: IC 4-21.5-3; IC 27-1-1-1

Sec. 6. Any order or decision of the commissioner of the department of insurance shall be subject to judicial review as permitted by IC 4-21.5-3 et seq. *(Department of Insurance; 760 IAC 1-53-6; filed Aug 24, 1993, 5:00 p.m.: 17 IR 10; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-53-7 Separability

Authority: IC 27-1-3-7
Affected: IC 27-1-1-1

Sec. 7. If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby. *(Department of Insurance; 760 IAC 1-53-7; filed Aug 24, 1993, 5:00 p.m.: 17 IR 10; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 54. Limitations on Investments in Subsidiaries

760 IAC 1-54-1 Authority and scope

Authority: IC 27-1-23-7; IC 27-2-9-3
Affected: IC 27-1-5-1; IC 27-1-13-3; IC 27-1-23-4; IC 27-2-9-3

Sec. 1. (a) This rule is adopted and promulgated by the department of insurance under IC 27-2-9-3(h)(3) and IC 27-1-23-7, and is applicable to every company other than a company organized as a life insurance company, organized under the provisions of IC 27-1 or any other law of this state and authorized to make any or all kinds of insurance described in Class 2 or Class 3 of IC 27-1-5-1.

(b) This rule does not apply to or restrict an insurer's direct or indirect investment in a domestic, foreign, or alien insurance subsidiary which, for the purposes of this rule, includes:

(1) any entity engaged in any kind of insurance business authorized by the jurisdiction in which it is organized, including, but not limited to, Class I, II, and III, title insurance companies, surplus lines insurers, health maintenance organizations and other health delivery systems, third party administrators, reinsurance intermediaries, managing general agents, investment advisors solely providing investment advisory services to insurers, broker-dealers solely distributing insurance products issued under Class I, II, or III, insurance brokers, and insurance agents; and

(2) any entity rendering other services related to the operations of an insurance business, including, but not limited to,

information processing systems and contractors under federal health care financing and delivery programs.
(Department of Insurance; 760 IAC 1-54-1; filed Oct 18, 1994, 4:40 p.m.: 18 IR 529; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-54-2 Definitions

Authority: IC 27-1-23-7; IC 27-2-9-3
Affected: IC 27-1-13-3; IC 27-1-23-4; IC 27-2-9

Sec. 2. (a) The definitions as set forth in IC 27-1-23 shall apply for purposes of this rule in addition to the definition in this section.

(b) As used in this rule, "total investment of the insurer" means the total of:

(1) any direct investment by the insurer in an asset; and

(2) the insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of such subsidiary.

(Department of Insurance; 760 IAC 1-54-2; filed Oct 18, 1994, 4:40 p.m.: 18 IR 529; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-54-3 Allowable investments in subsidiaries

Authority: IC 27-1-23-7; IC 27-2-9-3
Affected: IC 27-1-13-3; IC 27-1-23-4; IC 27-2-9

Sec. 3. (a) In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted under IC 27-1, a domestic insurer to which this rule is applicable may also do the following:

(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one (1) or more subsidiaries, amounts which do not exceed ten percent (10%) of such insurer's assets, provided that after such investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of such investments, the following shall be included:

(A) Total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of such subsidiary whether or not represented by the purchase of capital stock or issuance of other securities.

(B) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities and all contributions to the capital or surplus of a subsidiary subsequent to its acquisition or formation.

(2) Invest any amount in common stock, preferred stock, debt obligations, and other securities of one (1) or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer provided that each such subsidiary agrees to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed the investment limitations specified in subdivision (1) or in any applicable provision of IC 27-1.

(3) With the prior approval of the commissioner, invest any greater amount in common stock, preferred stock, debt obligations, or other securities of one (1) or more subsidiaries, provided that after such investment the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(b) Whether any investment under subsection (a) meets the applicable requirements thereof is to be determined before such investment is made, by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested.

(c) If an insurer ceases to control a subsidiary, it shall dispose of any investment therein made under this section within three (3) years from the time of the cessation of control or within such further time as the commissioner may prescribe, unless at any time after the investment shall have been made, the investment shall have met the requirements for investment under IC 27-1, and the insurer has notified the commissioner thereof. *(Department of Insurance; 760 IAC 1-54-3; filed Oct 18, 1994, 4:40 p.m.: 18 IR 529; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 55. Life and Accident and Health Insurers; Reinsurance Agreements

760 IAC 1-55-1 Authority

Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10

Sec. 1. This rule is adopted and promulgated pursuant to IC 27-1-3-7 and IC 27-6-10-15. *(Department of Insurance; 760 IAC 1-55-1; filed Nov 14, 1994, 10:30 a.m.: 18 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-55-2 Preamble

Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-1-20-21; IC 27-6-10; IC 27-9-2-1

Sec. 2. (a) The department of insurance recognizes that licensed insurers routinely enter into reinsurance agreements that yield legitimate relief to the ceding insurer from strain to surplus.

(b) However, it is improper for a licensed insurer, in the capacity of ceding insurer, to enter into reinsurance agreements for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business being reinsured. In substance or effect, the expected potential liability to the ceding insurer remains basically unchanged by the reinsurance transaction, notwithstanding certain risk elements in the reinsurance agreement, such as catastrophic mortality or extraordinary survival. The terms of such agreements referred to in this subsection and described in section 4 of this rule violate:

(1) IC 27-1-20-21 relating to financial statements which do not properly reflect the financial condition of the ceding insurer;

(2) 760 IAC 1-56 relating to reinsurance reserve credits, thus resulting in a ceding insurer improperly reducing liabilities or establishing assets for reinsurance ceded; and

(3) IC 27-9-2-1 relating to creating a situation that may be hazardous to policyholders and the people of this state.

(Department of Insurance; 760 IAC 1-55-2; filed Nov 14, 1994, 10:30 a.m.: 18 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-55-3 Scope

Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10

Sec. 3. This rule shall apply to all domestic life and accident and health insurers and to all other licensed life and accident and health insurers who are not subject to a substantially similar regulation in their domiciliary state. This rule shall also similarly apply to licensed property and casualty insurers with respect to their accident and health business. This rule shall not apply to assumption reinsurance, yearly renewable term reinsurance, or certain nonproportional reinsurance such as stop loss or catastrophe reinsurance. *(Department of Insurance; 760 IAC 1-55-3; filed Nov 14, 1994, 10:30 a.m.: 18 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-55-4 Accounting requirements

Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10

Sec. 4. (a) No insurer subject to this rule shall, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with the department of insurance if, by the terms of the reinsurance agreement, in substance or effect, any of the following conditions exist:

(1) Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period, are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured, unless a liability is established for the present value of the shortfall (using assumptions equal to the applicable statutory reserve basis on the business reinsured). Those expenses include commissions, premium taxes, and direct expenses,

including, but not limited to, billing, valuation, claims, and maintenance expected by the company at the time the business is reinsured.

(2) The ceding insurer can be deprived of surplus at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest, and adjustments on funds withheld, and tax reimbursements, shall not be considered to be such a deprivation of surplus.

(3) The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in-force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding company to prematurely terminate the reinsurance treaty.

(4) The ceding insurer must, at specific points in time scheduled in the agreement, terminate or automatically recapture all or part of the reinsurance ceded.

(5) The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. For example, it is improper for a ceding company to pay reinsurance premiums or other fees or charges to a reinsurer which are greater than the direct premiums collected by the ceding company.

(6) The treaty does not transfer all of the significant risks inherent in the business being reinsured. The table in this subdivision identifies, for a representative sampling of products or type of business, the risks which are considered to be significant. For products not specifically included, the risks determined to be significant shall be consistent with the following:

Risk categories:

a = Morbidity.

b = Mortality.

c = Lapse. This is the risk that a policy will voluntarily terminate prior to the recoupment of any statutory surplus strain experienced at issue of the policy.

d = Credit quality (C1). This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate.

e = Reinvestment (C3). This is the risk that interest rates will fall and funds reinvested (coupon payments or monies received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase.

f = Disintermediation (C3). This is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.

\+ = Significant.

o = Insignificant.

	Risk Category					
	a	b	c	d	e	f
Health insurance–other than LTC/LTD*	+	o	+	o	o	o
Health insurance–LTC/LTD*	+	o	+	+	+	o
Immediate annuities	o	+	o	+	+	o
Single premium deferred annuities	o	o	+	+	+	+
Flexible premium deferred annuities	o	o	+	+	+	+
Guaranteed interest contracts	o	o	o	+	+	+

Other annuity deposit business	o	o	+	+	+	+
Single premium whole life	o	+	+	+	+	+
Traditional non-par permanent	o	+	+	+	+	+
Traditional non-par term	o	+	+	o	o	o
Traditional par permanent	o	+	+	+	+	+
Traditional par term	o	+	+	o	o	o
Adjustable premium permanent	o	+	+	+	+	+
Indeterminate premium permanent	o	+	+	+	+	+
Universal life flexible premium	o	+	+	+	+	+
Universal life fixed premium	o	+	+	+	+	+
Universal life fixed premium dump-in premiums allowed	o	+	+	+	+	+

*LTC = long term care insurance.
LTD = long term disability insurance.

(7)(A) The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not (other than for the classes of business excepted in clause (B)) either transfer the underlying assets to the reinsurer or legally segregate such assets in a trust or escrow account or otherwise establish a mechanism satisfactory to the commissioner which legally segregates the underlying assets.

(B) Notwithstanding the requirements of clause (A), the assets supporting the reserves for the following classes of business and any classes of business which do not have a significant credit quality, reinvestment, or disintermediation risk may be held by the ceding company without segregation of such assets:

(i) Health insurance–LTC/LTD.
(ii) Traditional non-par permanent.
(iii) Traditional par permanent.
(iv) Adjustable premium permanent.
(v) Indeterminate premium permanent.
(vi) Universal life fixed premium (no dump-in premiums allowed).

The associated formula for determining the reserve interest rate adjustment must use a formula which reflects the ceding company's investment earnings and incorporates all realized and unrealized gains and losses reflected in the preceding year's statutory statement. The following is an acceptable formula:

$$\text{Rate} = \frac{2\ (I + CG)}{X + Y - I - CG}$$

Where:
- I = the net investment income (Exhibit 2, Line 16, Column 7).
- CG = capital gains less capital losses (Exhibit 4, Line 10, Column 6).
- X = the current year cash and invested assets (Page 2, Line 10A, Column 1) plus investment income due and accrued (Page 2, Line 16, Column 1) less borrowed money (Page 3, Line 22, Column 1).
- Y = the same as X but for the prior year.

(8) Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date.

(9) The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured.

(10) The ceding insurer is required to make representations or warranties about future performance of the business being reinsured.

(11) The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured.

(b) Notwithstanding subsection (a), an insurer subject to this rule may, with the approval of the commissioner of the department of insurance, take such reserve credit or establish such asset as the commissioner of the department of insurance may

deem consistent with Indiana insurance law and rules, including actuarial interpretations or standards adopted by the department of insurance.

(c)(1) Agreements entered into after the effective date of this rule which involve the reinsurance of business issued prior to the effective date of the agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the commissioner of the department of insurance within thirty (30) days from its date of execution. Each such filing shall include data detailing the financial impact of the transaction. A retrocession agreement and its corresponding accepted reinsurance agreement shall be treated as a single transaction for these purposes. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this rule and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with the department of insurance. The actuary should maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statement and to demonstrate that such work conforms to this rule.

(2) Any increase in surplus net of federal income tax resulting from arrangements described in subdivision (1) shall be identified separately on the insurer's statutory financial statement as a surplus item (aggregate write-ins for gains and losses in surplus in the capital and surplus account, page 4 of the annual statement) and recognition of the surplus increase as income shall be reflected on a net of tax basis in the "reinsurance ceded" line, page 4 of the annual statement, as earnings emerge from the business reinsured. For example, on the last day of calendar year N, Company XYZ pays a twenty million dollar ($20,000,000) initial commission and expense allowance to company ABC for reinsuring an existing block of business. Assuming a thirty-four percent (34%) tax rate, the net increase in surplus at inception is thirteen million two hundred thousand dollars ($13,200,000) (twenty million dollars ($20,000,000) - six million eight hundred thousand dollars ($6,800,000)) which is reported on the "aggregate write-ins for gains and losses in surplus" line in the capital and surplus account. Six million eight hundred thousand dollars ($6,800,000) (thirty-four percent (34%) of twenty million dollars ($20,000,000)) is reported as income on the "commissions and expense allowances on reinsurance ceded" line of the summary of operations. At the end of year N + 1, the business has earned four million dollars ($4,000,000). ABC has paid five hundred thousand dollars ($500,000) in profit and risk charges in arrears for the year and has received a one million dollar ($1,000,000) experience refund. Company ABC's annual statement would report one million six hundred fifty thousand dollars ($1,650,000) (sixty-six percent (66%) of (four million dollars ($4,000,000) - one million dollars ($1,000,000) - five hundred thousand dollars ($500,000)) up to a maximum of thirteen million two hundred thousand dollars ($13,200,000)) on the "commissions and expense allowance on reinsurance ceded" line of the summary of operations, and one million six hundred fifty thousand dollars ($1,650,000) on the "aggregate write-ins for gains and losses in surplus" line of the capital and surplus account. The experience refund would be reported separately as a miscellaneous income item in the summary of operations.

(Department of Insurance; 760 IAC 1-55-4; filed Nov 14, 1994, 10:30 a.m.: 18 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-55-5 Written agreements

Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10

Sec. 5. (a) No reinsurance agreement or amendment to any agreement may be used to reduce any liability or to establish any asset in any financial statement filed with the department of insurance unless the agreement, amendment, or a binding letter of intent has been duly executed by both parties no later than the "as of date" of the financial statement.

(b) In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding ninety (90) days from the execution date of the letter of intent, in order for credit to be granted for the reinsurance ceded.

(c) The reinsurance agreement shall contain provisions which provide in substance or effect:

(1) that the agreement shall constitute the entire agreement between the parties with respect to the business being reinsured thereunder and that there are no understandings between the parties other than as expressed in the agreement; and

(2) any change or modification to the agreement shall be null and void unless made by amendment to the agreement and signed by both parties.

(Department of Insurance; 760 IAC 1-55-5; filed Nov 14, 1994, 10:30 a.m.: 18 IR 869; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-55-6 Existing agreements
Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10

Sec. 6. Insurers subject to this rule shall reduce to zero (0) by December 31, 1994, any reserve credits or assets established with respect to reinsurance agreements entered into prior to the effective date of this rule which, under the provisions of this rule, would not be entitled to recognition of such reserve credits or assets, provided, however, that such reinsurance agreements shall have been in compliance with laws or rules in existence immediately preceding the effective date of this rule. *(Department of Insurance; 760 IAC 1-55-6; filed Nov 14, 1994, 10:30 a.m.: 18 IR 870; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 56. Credit for Reinsurance

760 IAC 1-56-1 Authority
Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10

Sec. 1. This rule is promulgated pursuant to the authority granted by IC 27-1-3-7 and IC 27-6-10-15. *(Department of Insurance; 760 IAC 1-56-1; filed Nov 14, 1994, 9:50 a.m.: 18 IR 870; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-56-2 Purpose
Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10

Sec. 2. The purpose of this rule is to set forth rules and procedural requirements which the commissioner of the department of insurance deems necessary to carry out the provisions of IC 27-6-10. The actions and information required by this rule are hereby declared to be necessary and appropriate in the public interest and for the protection of the ceding insurers in this state. *(Department of Insurance; 760 IAC 1-56-2; filed Nov 14, 1994, 9:50 a.m.: 18 IR 870; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-56-3 Severability
Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10

Sec. 3. If any provision of this rule or its application to any person or circumstance is held invalid, such determination shall not affect other provisions or applications of this rule which can be given effect without the invalid provision or application, and to that end the provisions of this rule are severable. *(Department of Insurance; 760 IAC 1-56-3; filed Nov 14, 1994, 9:50 a.m.: 18 IR 870; errata filed Mar 9, 1995, 3:00 p.m.: 18 IR 1837; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-56-4 Reinsurer licensed in Indiana
Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10-8

Sec. 4. Under IC 27-6-10-8, the commissioner of the department of insurance shall allow credit for reinsurance ceded by a domestic insurer to assuming insurers which were licensed in this state as of the date of the ceding insurer's statutory financial statement. *(Department of Insurance; 760 IAC 1-56-4; filed Nov 14, 1994, 9:50 a.m.: 18 IR 870; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-56-5 Accredited reinsurers
Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10-9

Sec. 5. (a) Under IC 27-6-10-9, the commissioner of the department of insurance shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which is accredited as a reinsurer in this state as of the date of the ceding insurer's statutory financial statement. An accredited reinsurer is one which:

(1) files a properly executed Form AR-1, as established in section 15 of this rule, as evidence of its submission to this state's jurisdiction and to this state's authority to examine its books and records;

(2) files with the commissioner of the department of insurance a certified copy of a letter or a certificate of authority or of compliance as evidence that it is licensed to transact insurance or reinsurance in at least one (1) state or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one (1) state;

(3) files annually with the commissioner of the department of insurance a copy of its annual statement filed with the department of insurance of its state of domicile or, in the case of an alien assuming insurer, with the state through which it is entered and in which it is licensed to transact insurance or reinsurance, and a copy of its most recent audited financial statement; and

(4) maintains a surplus as regards policyholders in an amount not less than twenty million dollars ($20,000,000) and whose accreditation has not been denied by the commissioner of the department of insurance within ninety (90) days of its submission or, in the case of companies with a surplus as regards policyholders of less than twenty million dollars ($20,000,000), whose accreditation has been approved by the commissioner of the department of insurance.

(b) If the commissioner of the department of insurance determines that the assuming insurer has failed to meet or maintain any of the qualifications in this section, he or she may, upon written notice and hearing, revoke the accreditation. No credit shall be allowed a domestic ceding insurer with respect to reinsurance ceded after the next following year-end if the assuming insurer's accreditation has been denied or revoked by the commissioner of the department of insurance after notice and hearing. *(Department of Insurance; 760 IAC 1-56-5; filed Nov 14, 1994, 9:50 a.m.: 18 IR 871; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-56-6 Reinsurer domiciled and licensed in another state

Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10-10

Sec. 6. (a) Under IC 27-6-10-10, the commissioner of the department of insurance shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which, as of the date of the ceding insurer's statutory financial statement:

(1) is domiciled and licensed in (or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed in) a state which employs standards regarding credit for reinsurance substantially similar to those applicable under this rule;

(2) maintains a surplus as regards policyholders in an amount not less than twenty million dollars ($20,000,000); and

(3) files a properly executed Form AR-1 with the commissioner of the department of insurance as evidence of its submission to the state's authority to examine its books and records.

(b) The provisions of this section relating to surplus as regards policyholders shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system. As used in this section, "substantially similar" standards means credit for reinsurance standards which the commissioner of the department of insurance determines equal or exceed the standards of this rule. *(Department of Insurance; 760 IAC 1-56-6; filed Nov 14, 1994, 9:50 a.m.: 18 IR 871; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-56-7 Reinsurers maintaining trust funds

Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10-6; IC 27-6-10-11

Sec. 7. (a) Under IC 27-6-10-11, the commissioner of the department of insurance shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which, as of the date of the ceding insurer's statutory financial statement, maintains a trust fund in an amount prescribed in this section in a qualified United States financial institution, as defined in IC 27-6-10-6, for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the commissioner of the department of insurance substantially the same information as that

required to be reported on the National Association of Insurance Commissioners' annual statement form by licensed insurers, to enable the commissioner of the department of insurance to determine the sufficiency of the trust fund.

(b) The following requirements apply to the following categories of assuming insurer:

(1) The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to business written in the United States and, in addition, a trusteed surplus of not less than twenty million dollars ($20,000,000).

(2) The trust fund for a group including incorporated and individual unincorporated underwriters shall consist of funds in trust in an amount not less than the group's aggregate liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which one hundred million dollars ($100,000,000) shall be held jointly for the benefit of the United States ceding insurers of any member of the group and, in addition, the incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members. The group shall make available to the commissioner of the department of insurance annual certifications by the group's domiciliary regulator and its independent public accountants of the solvency of each underwriter member of the group.

(3) The trust fund for a group of incorporated insurers under common administration, whose members possess aggregate policyholders surplus of ten billion dollars ($10,000,000,000) (calculated and reported in substantially the same manner as prescribed by the annual statement instructions and Accounting Practices and Procedures Manual of the National Association of Insurance Commissioners) and which has continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to making application for accreditation, shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to business ceded by United States ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group and, in addition, the group shall maintain a joint trusteed surplus of which one hundred million dollars ($100,000,000) shall be held jointly for the benefit of United States ceding insurers of any member of the group. The group shall file a properly executed Form AR-1 as evidence of the submission to this state's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination. The group shall make available to the commissioner of the department of insurance annual certifications by the members' domiciliary regulators and their independent public accountants of the solvency of each member of the group.

(c) The trust shall be established in a form approved by the commissioner of the department of insurance and complying with IC 27-6-10-11 and this section. The trust instrument shall provide the following:

(1) Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied thirty (30) days after entry of the final order of any court of competent jurisdiction in the United States.

(2) Legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's United States policyholders and ceding insurers, their assigns and successors in interest.

(3) The trust shall be subject to examination as determined by the commissioner of the department of insurance.

(4) The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations under reinsurance agreements subject to the trust.

(5) No later than February 28 of each year, the trustees of the trust shall report to the commissioner of the department of insurance in writing setting forth the balance in the trust and listing the trust's investments at the preceding year end and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31.

(6) No amendment to the trust shall be effective unless reviewed and approved in advance by the commissioner of the department of insurance.

(Department of Insurance; 760 IAC 1-56-7; filed Nov 14, 1994, 9:50 a.m.: 18 IR 871; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-56-8 Credit reinsurance required by law

Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10

Sec. 8. Under IC 27-6-10-13, the commissioner of the department of insurance shall allow credit for reinsurance ceded by

a domestic insurer to an assuming insurer not meeting the requirements of IC 27-6-10-8, IC 27-6-10-9, IC 27-6-10-10, or IC 27-6-10-11, but only with respect to the insurance of risks located in jurisdictions where such reinsurance is required by the applicable law or regulation of that jurisdiction. As used in this section, "jurisdiction" means any state, district, or territory of the United States and any lawful national government. *(Department of Insurance; 760 IAC 1-56-8; filed Nov 14, 1994, 9:50 a.m.: 18 IR 872; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-56-9 Reduction from liability for reinsurance ceded to an unauthorized assuming insurer

Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10

Sec. 9. (a) Under IC 27-6-10-14, the commissioner of the department of insurance shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of IC 27-6-10-8, IC 27-6-10-9, IC 27-6-10-10, or IC 27-6-10-11 in an amount not exceeding the liabilities carried by the ceding insurer. Such reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder. Such security must be held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution as defined in IC 27-6-10-6.

(b) The security required by subsection (a) may be in the form of any of the following:

(1) Cash.

(2) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as admitted assets.

(3) Clean, irrevocable, unconditional, and evergreen letters of credit issued or confirmed by a qualified United States institution, as defined in IC 27-6-10-5, effective no later than December 31 of the year for which filing is being made, and in the possession of the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institutions' subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever first occurs.

(4) Any other form of security acceptable to the commissioner of the department of insurance.

(c) An admitted asset or reduction from liability for reinsurance ceded to an unauthorized assuming insurer under subsection (b)(1), (b)(2), or (b)(3) shall be allowed only when the requirements of section 10, 11, or 12 of this rule are met. *(Department of Insurance; 760 IAC 1-56-9; filed Nov 14, 1994, 9:50 a.m.: 18 IR 872; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-56-10 Trust agreements qualified under section 9 of this rule

Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10-6

Sec. 10. (a) The following definitions apply throughout this section:

(1) "Beneficiary" means the entity for whose sole benefit the trust has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator, or liquidator).

(2) "Grantor" means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.

(3) "Obligations", as used in subsection (b)(11), means the following:

(A) Reinsured losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer.

(B) Reserves for reinsured losses reported and outstanding.

(C) Reserves for reinsured losses incurred but not reported.

(D) Reserves for allocated reinsured loss expenses and unearned premiums.

(4) "Trust agreement" means an agreement whereby assets are placed in trust for the purpose of securing reserve credit for a ceding insurer as provided in section 9 of this rule.

(b) The following are required conditions:

(1) The trust agreement shall be entered into between the beneficiary, the grantor, and the trustee which shall be a qualified United States financial institution as defined in IC 27-6-10-6.

(2) The trust agreement shall create a trust account into which assets shall be deposited.

(3) All assets in the trust account shall be held by the trustee at the trustee's office in the United States, except that a bank may apply for permission by the commissioner of the department of insurance to use a foreign branch office of such bank as trustee for trust agreements established under this section. If the commissioner of the department of insurance approves the use of such foreign branch office as trustee, then its use must be approved by the beneficiary in writing and the trust agreement must provide that the written notice described in subdivision (4)(A) must also be presentable, as a matter of legal right, at the trustee's principal office in the United States.

(4) The trust agreement shall provide that:

(A) the beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;

(B) no other statement or document is required to be presented in order to withdraw assets except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

(C) it is not subject to any conditions or qualifications outside of the trust agreement; and

(D) it shall not contain references to any other agreements or documents except as provided for under subdivision (11).

(5) The trust agreement shall be established for the sole benefit of the beneficiary.

(6) The trust agreement shall require the trustee to do the following:

(A) Receive assets and hold all assets in a safe place.

(B) Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity.

(C) Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequently than the end of each calendar quarter.

(D) Notify the grantor and the beneficiary within ten (10) days of any deposits to or withdrawals from the trust account.

(E) Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title, and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary.

(F) Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

(7) The trust agreement shall provide that at least thirty (30) days, but not more than forty-five (45) days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.

(8) The trust agreement shall be made subject to and governed by the laws of the state in which the trust is established.

(9) The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.

(10) The trust agreement shall provide that the trustee shall be liable for its own negligence, willful misconduct, or lack of good faith.

(11) Notwithstanding other provisions of this rule, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, such a trust agreement may, notwithstanding any other conditions in this rule, provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, for any of the following purposes:

(A) To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer.

(B) To make payment to the assuming insurer of any amounts held in the trust account that exceed one hundred two percent (102%) of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement.

(C) Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged for ten (10) days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution as defined in IC 27-6-10-6 apart from its general assets, in trust for such uses and purposes specified in clauses (A) and (B) as may remain executory after such withdrawal and for any period after the termination date.

(12) The reinsurance agreement entered into in conjunction with the trust agreement may, but need not, contain the provisions required by subsection (d)(1)(B), so long as these required conditions are included in the trust agreement.

(c) The following are permitted conditions:

(1) The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than ninety (90) days after receipt by the beneficiary and grantor of the notice and that the trustee may be removed by the grantor by delivery to the trustee and beneficiary of the written notice of removal, effective not less than ninety (90) days after receipt by the trustee and the beneficiary of the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

(2) The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any such interest or dividend shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

(3) The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in subsection (d)(1)(B).

(4) The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Such transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.

(5) The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

(d) The following are additional conditions applicable to reinsurance agreements:

(1) A reinsurance agreement, which is entered into in conjunction with a trust agreement and the establishment of a trust account, may contain provisions that do the following:

(A) Require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, specifying what the agreement is to cover.

(B) Stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of:

(i) cash (United States legal tender);

(ii) certificates of deposit (issued by a United States bank and payable in United States legal tender);

(iii) investments of the types permitted by the Insurance Code; or

(iv) any combination of items (i) through (iii);

provided that such investments are issued by an institution that is not the parent, subsidiary, or affiliate of either the grantor or the beneficiary. The reinsurance agreement may further specify the types of investments to be deposited. Where a trust agreement is entered into in conjunction with a reinsurance agreement covering risks other than life, annuities, accident, and health, then the trust agreement may contain the provisions required by this clause in lieu of including such provisions in the reinsurance agreement.

(C) Require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations, or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or signature from the assuming insurer or any other entity.

(D) Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its

equivalent.

(E) Stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including, without limitation, any liquidator, rehabilitator, receiver, or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:

(i) To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies.

(ii) To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement.

(iii) To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer liabilities for policies ceded under the agreement. The account shall include, but not be limited to, amounts for policy reserves, claims, and losses incurred (including losses incurred but not reported), loss adjustment expenses, and unearned premium reserves.

(iv) To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

(2) The reinsurance agreement may also contain provisions that do the following:

(A) Give the assuming insurer the right to seek approval from the ceding insurer to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:

(i) the assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount; or

(ii) after withdrawal and transfer, the market value of the trust account is no less than one hundred two percent (102%) of the required amount.

The ceding insurer shall not unreasonably or arbitrarily withhold its approval.

(B) Provide for:

(i) the return of any amount withdrawn in excess of the actual amounts required for subdivision (1)(E)(i), (1)(E)(ii), and (1)(E)(iii) or, in the case of subdivision (1)(E)(iv), any amounts that are subsequently determined not to be due; and

(ii) interest payments, at a rate not in excess of the prime rate of interest, on the amounts held under subdivision (1)(E)(iii).

(C) Permit the award by any arbitration panel or court of competent jurisdiction of:

(i) interest at a rate different from that provided in clause (B)(ii);

(ii) court of arbitration costs;

(iii) attorney's fees; and

(iv) any other reasonable expenses.

(3) A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with the department of insurance in compliance with this rule when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

(4) Notwithstanding the effective date of this rule, any trust agreement or underlying reinsurance agreement in existence prior to December 31, 1994, will continue to be acceptable until December 31, 1995, at which time the agreements will have to be in full compliance with this rule for the trust agreement to be acceptable.

(5) The failure of any trust agreement to specifically identify the beneficiary as defined in subsection (a)(1) shall not be construed to affect any actions or rights which the commissioner of the department of insurance may take or possess pursuant to the provisions of the laws of this state.

(Department of Insurance; 760 IAC 1-56-10; filed Nov 14, 1994, 9:50 a.m.: 18 IR 873; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 1-56-11 Letters of credit qualified under section 9 of this rule

Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10-5

Sec. 11. (a) The letter of credit must be clean, irrevocable, and unconditional and issued or confirmed by a qualified United States financial institution as defined in IC 27-6-10-5. The letter of credit shall contain an issue date and date of expiration and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit shall also indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents, or entities, except as provided in subsection (i)(1). As used in this section, "beneficiary" means the domestic insurer for whose benefit the letter of credit has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes, and is limited to, the court appointed domiciliary receiver (including conservator, rehabilitator, or liquidator).

(b) The heading of the letter of credit may include a boxed section which contains the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

(c) The letter of credit shall contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

(d) The term of the letter of credit shall be for at least one (1) year and shall contain an evergreen clause which prevents the expiration of the letter of credit without due notice from the issuer. The evergreen clause shall provide for a period of no less than a thirty (30) day notice prior to expiry date or nonrenewal.

(e) The letter of credit shall state whether it is subject to and governed by the laws of this state or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 500), and all drafts drawn thereunder shall be presentable at an office in the United States of a qualified United States financial institution.

(f) If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 500), then the letter of credit shall specifically address and make provisions for an extension of time to draw against the letter of credit in the event that one (1) or more of the occurrences specified in Article 17 of Publication 500 occur.

(g) The letter of credit shall be issued or confirmed by a qualified United States financial institution authorized to issue letters of credit under IC 27-6-10-5.

(h) If the letter of credit is issued by a qualified United States financial institution authorized to issue letters of credit, other than a qualified United States financial institution as described in subsection (g), then the following additional requirements shall be met:

(1) The issuing qualified United States financial institution shall formally designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts.

(2) The evergreen clause shall provide for a thirty (30) day notice prior to expiry date for nonrenewal.

(i) Reinsurance agreement provisions shall be as follows:

(1) The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions which do the following:

(A) Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover.

(B) Stipulate that the assuming insurer and the ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provision in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one (1) or more of the following reasons:

(i) To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies.

(ii) To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer under the terms and provisions of the policies reinsured under the reinsurance agreement.

(iii) To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer's liabilities for policies ceded under the agreement (such amount shall include,

but not be limited to, amounts for policy reserves, claims and losses incurred, and unearned premium reserves).

(iv) To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

(C) This subdivision shall be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

(2) Nothing contained in subdivision (1) shall preclude the ceding insurer and assuming insurer from providing for either or both of the following:

(A) An interest payment, at a rate not in excess of the prime rate of interest, on the amounts held under subdivision (1)(B)(iii).

(B) The return of any amounts drawn down on the letters of credit in excess of the actual amounts required in subdivision (1)(B) or, in the case of subdivision (1)(B)(iv), any amounts that are subsequently determined not to be due.

(3) When a letter of credit is obtained in conjunction with a reinsurance agreement covering risks other than life, annuities, and health, where it is customary practice to provide a letter of credit for a specific purpose, then the reinsurance agreement may, in lieu of subdivision (1)(B), require that the parties enter into a trust agreement which may be incorporated into the reinsurance agreement or be a separate document.

(j) A letter of credit may not be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with the department of insurance unless an acceptable letter of credit with the filing ceding insurer as beneficiary has been issued on or before the date of filing of the financial statement. Further, the reduction for the letter of credit may be up to the amount available under the letter of credit but no greater than the specific obligation under the reinsurance agreement which the letter of credit was intended to secure. *(Department of Insurance; 760 IAC 1-56-11; filed Nov 14, 1994, 9:50 a.m.: 18 IR 876; errata filed Mar 9, 1995, 3:00 p.m.: 18 IR 1837; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-56-12 Other security

Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10

Sec. 12. A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States subject to withdrawal solely by the ceding insurer and under its exclusive control. *(Department of Insurance; 760 IAC 1-56-12; filed Nov 14, 1994, 9:50 a.m.: 18 IR 877; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-56-13 Reinsurance contract

Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10-7; IC 27-6-10-12

Sec. 13. (a) Credit will not be granted to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of section 4, 5, 6, 7, or 9 of this rule or otherwise in compliance with IC 27-6-10-7 after the adoption of this rule unless the reinsurance agreement includes the following:

(1) An insolvency clause such that the amount recoverable by a domestic ceding company or its receiver may not be reduced as a result of delinquency proceedings involving the assuming insurer. Nothing in this subsection shall prohibit the setoff of mutual debts and credits between the ceding insurer and the assuming insurer.

(2) A provision under IC 27-6-10-12, whereby the assuming insurer, if an unauthorized assuming insurer:

(A) has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States;

(B) has agreed to comply with all requirements necessary to give such court or panel jurisdiction;

(C) has designated an agent upon whom service of process may be effected; and

(D) has agreed to abide by the final decision of such court or panel.

(b) Provided that the requirements of this section and IC 27-6-10-12 are met, this rule does not require that the parties to a reinsurance transaction agree to mandatory arbitration. *(Department of Insurance; 760 IAC 1-56-13; filed Nov 14, 1994, 9:50 a.m.: 18 IR 877; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-56-14 Contracts affected

Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10

Sec. 14. All new and renewal reinsurance transactions entered into after December 31, 1994, shall conform to the requirements of this rule if credit is to be given to the ceding insurer for such reinsurance. *(Department of Insurance; 760 IAC 1-56-14; filed Nov 14, 1994, 9:50 a.m.: 18 IR 878; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 1-56-15 Certificate of assuming insurer, form AR-1

Authority: IC 27-1-3-7; IC 27-6-10-15
Affected: IC 27-6-10

Sec. 15. Form AR-1, Certificate of Assuming Insurer, shall be as follows:

FORM AR-1
CERTIFICATE OF ASSUMING INSURER

I, (name of officer), (title of officer) of (name of assuming insurer), the assuming insurer under a reinsurance agreement(s) with one (1) or more insurers domiciled in (name of State), hereby certify that (name of assuming insurer) ("Assuming insurer"):

1. Submits to the jurisdiction of any court of competent jurisdiction in (ceding insurer's state of domicile) for the adjudication of any issues arising out of the reinsurance agreement(s), agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement(s) to arbitrate their disputes if such an obligation is created in the agreement(s).
2. Designate the Insurance Commissioner of (ceding insurer's state of domicile) as its lawful attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement(s) instituted by or on behalf of the ceding insurer.
3. Submits to the authority of the Insurance Commissioner of (ceding insurer's state of domicile) to examine its books and records and agrees to bear the expense of any such examination.
4. Submits with this form a current list of insurers domiciled in (ceding insurer's state of domicile) reinsured by Assuming Insurer and undertakes to submit additions to or deletions from the list to the Insurance Commissioner at least once per calendar quarter.

Dated: _____

_____
(name of assuming insurer)

BY: _____
(name of officer)

_____
(title of officer)

(Department of Insurance; 760 IAC 1-56-15; filed Nov 14, 1994, 9:50 a.m.: 18 IR 878; errata, 18 IR 1291; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 57. Actuarial Opinion and Memorandum

760 IAC 1-57-1 Authority

Authority: IC 27-1-12-10.1
Affected: IC 27-1-12-10

Sec. 1. This rule is promulgated pursuant to the authority granted by IC 27-1-12-10.1. *(Department of Insurance; 760 IAC 1-57-1; filed May 16, 1997, 9:30 a.m.: 20 IR 2778; filed Oct 6, 2003, 5:15 p.m.: 27 IR 505, eff Dec 31, 2003)*

760 IAC 1-57-2 Purpose

Authority: IC 27-1-12-10.1
Affected: IC 27-1-12-10.1

Sec. 2. The purpose of this rule is to prescribe the following:

(1) Guidelines and standards for statements of actuarial opinion that are to be submitted in accordance with IC 27-1-12-10.1 and for memoranda in support thereof.

(2) Rules applicable to the appointment of an appointed actuary.

(Department of Insurance; 760 IAC 1-57-2; filed May 16, 1997, 9:30 a.m.: 20 IR 2778; filed Oct 6, 2003, 5:15 p.m.: 27 IR 505, eff Dec 31, 2003)

760 IAC 1-57-3 Scope

Authority: IC 27-1-12-10.1
Affected: IC 27-1-12-10; IC 27-11-8-2

Sec. 3. (a) This rule shall apply to:

(1) all life insurance companies and fraternal benefit societies doing business in this state;

(2) all life insurance companies and fraternal benefit societies that are authorized to reinsure life insurance, annuities, or accident and health insurance business in this state; and

(3) any annual statement filed with the commissioner after the effective date of this rule.

(b) A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with section 8 of this rule, and a memorandum in support thereof in accordance with section 9 of this rule, shall be required each year. *(Department of Insurance; 760 IAC 1-57-3; filed May 16, 1997, 9:30 a.m.: 20 IR 2778; filed Oct 6, 2003, 5:15 p.m.: 27 IR 505, eff Dec 31, 2003)*

760 IAC 1-57-4 Definitions

Authority: IC 27-1-12-10.1
Affected: IC 27-1-12-10; IC 27-1-20-21

Sec. 4. The following definitions apply throughout this rule, IC 27-1-12-10, and IC 27-1-12-10.1:

(1) "Actuarial opinion" means the opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy test in accordance with section 8 of this rule and with presently accepted actuarial standards.

(2) "Actuarial Standards Board" means the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

(3) "Annual statement" means the statement required by IC 27-1-20-21 to be filed by the company with the department annually.

(4) "Appointed actuary" means any individual who meets the requirements of section 5(c) of this rule.

(5) "Asset adequacy analysis" means an analysis that meets the requirements of section 5(d) of this rule. The term includes cash flow testing, sensitivity testing, or applications of risk theory.

(6) "Commissioner" means the commissioner of the department of insurance.

(7) "Company" means a life insurance company, fraternal benefit society, or reinsurer subject to this rule.

(8) "Department" means the department of insurance.

(9) "NAIC" means the National Association of Insurance Commissioners.

(10) "Noninvestment grade bonds" means bonds designated as Class 3, 4, 5, or 6 by the NAIC securities valuation office.

(11) "Qualified actuary" means any individual who meets the requirements of section 5(b) of this rule.

(Department of Insurance; 760 IAC 1-57-4; filed May 16, 1997, 9:30 a.m.: 20 IR 2778; filed Oct 6, 2003, 5:15 p.m.: 27 IR 506, eff Dec 31, 2003)

760 IAC 1-57-5 General requirements

Authority: IC 27-1-12-10.1
Affected: IC 27-1-12-10

Sec. 5. (a) Requirements for the submission of statement of actuarial opinion shall be as follows:

(1) A statement entitled "Statement of Actuarial Opinion" that meets the requirements of section 8 of this rule and is rendered by an appointed actuary shall be included on or attached to page 1 of the annual statement of any company.

(2) The commissioner may grant an extension of the date for submission of the statement of actuarial opinion upon written request by a company.

(b) As used in this section, "qualified actuary" means an individual who:

(1) is a member in good standing of the American Academy of Actuaries;

(2) is qualified to sign a statement of actuarial opinion for any life or health insurance company annual statement in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements;

(3) is familiar with the valuation requirements applicable to life and health insurance companies;

(4) has not been found by the commissioner (or, if so found, has been subsequently reinstated as a qualified actuary), following appropriate notice and hearing, to have:

(A) violated any provision of, or any obligation imposed by, IC 27 or other law in the course of his or her dealings as a qualified actuary;

(B) been found guilty of fraudulent or dishonest practices;

(C) demonstrated his or her incompetency, lack of cooperation, or untrustworthiness to act as a qualified actuary;

(D) submitted to the commissioner during the past five (5) years, pursuant to this rule, an actuarial opinion or memorandum that the commissioner rejected because it did not meet the provisions of this rule including standards set by the Actuarial Standards Board; or

(E) resigned or been removed as an actuary within the past five (5) years as a result of acts or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and

(5) has not failed to notify the commissioner of any action similar to that described in subdivision (4) taken by any insurance supervisory regulator of any other state.

(c) As used in this rule, "appointed actuary" means a qualified actuary who is appointed or retained to prepare the statement of actuarial opinion required by IC 27-1-12-10.1 and this rule, either directly by a company or by the authority of the board of directors through an executive officer of a company. Notice requirements shall be as follows:

(1) A company shall give the commissioner timely written notice of the name, title (and, in the case of a consulting actuary, the name of the firm), and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and shall state in such notice that the person meets the requirements in subsection (b).

(2) A company shall give the commissioner timely notice in the event an appointed actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in subsection (b).

(3) If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement.

(d) The asset adequacy analysis required by this rule shall:

(1) conform to the standards of practice promulgated by the Actuarial Standards Board and any additional standards under this rule, which standards are to form the basis of the statement of actuarial opinion in accordance with section 8 of this rule; and

(2) be based on methods of analysis deemed appropriate for such purposes by the Actuarial Standards Board.

(e) Liabilities to be covered shall be as follows:

(1) Pursuant to IC 27-1-12-10.1, the statement of actuarial opinion shall apply to all in force business on the annual statement date regardless of when or where issued.

(2) If the appointed actuary determines as the result of asset adequacy analysis that a reserve should be held in addition to the aggregate reserve held by the company and calculated in accordance with the methods set forth in IC 27-1-12-10, the company shall establish such additional reserve.

(3) Any additional reserve established under subdivision (2) and deemed not necessary in any subsequent year may be released. Any amount released must be disclosed in the actuarial opinion for the applicable year. The release of such reserves

shall not be deemed an adoption of a lower standard of valuation.

(Department of Insurance; 760 IAC 1-57-5; filed May 16, 1997, 9:30 a.m.: 20 IR 2779; filed Oct 6, 2003, 5:15 p.m.: 27 IR 506, eff Dec 31, 2003)

760 IAC 1-57-6 Required opinions

Authority: IC 27-1-12-10.1
Affected: IC 27-1-12-10.1

Sec. 6. In accordance with IC 27-1-12-10.1, every company doing business in this state shall annually submit a statement of actuarial opinion in accordance with section 8 of this rule for each year beginning with the year in which this rule becomes effective.

(Department of Insurance; 760 IAC 1-57-6; filed May 16, 1997, 9:30 a.m.: 20 IR 2780; filed Oct 6, 2003, 5:15 p.m.: 27 IR 507, eff Dec 31, 2003)

760 IAC 1-57-7 Statement of actuarial opinion not including an asset adequacy analysis (Repealed)

Sec. 7. *(Repealed by Department of Insurance; filed Oct 6, 2003, 5:15 p.m.: 27 IR 515, eff Dec 31, 2003)*

760 IAC 1-57-8 Statement of actuarial opinion based on an asset adequacy analysis

Authority: IC 27-1-12-10.1
Affected: IC 27-1-12-10.1

Sec. 8. (a) The statement of actuarial opinion based on an asset adequacy analysis required by IC 27-1-12-10.1 shall consist of the following:

(1) An opening paragraph.
(2) A scope paragraph.
(3) A reliance paragraph.
(4) An opinion paragraph.
(5) One (1) or more additional paragraphs will be needed in individual company cases as follows:
    (A) If the appointed actuary considers it necessary to state a qualification of his or her opinion.
    (B) If the appointed actuary must disclose the method or aggregation for reserves of different products or lines of business for asset adequacy analysis.
    (C) If the appointed actuary must disclose reliance upon any portion of the assets supporting the Asset Valuation Reserve (AVR), Interest Maintenance Reserve (IMR), or other mandatory or voluntary statement of reserves for asset adequacy analysis.
    (D) If the appointed actuary must disclose an inconsistency in the method of analysis or basis of asset allocation used at the prior opinion date with that used for this opinion.
    (E) If the appointed actuary must disclose whether additional reserves of the prior opinion date are released as of this opinion date, and the extent of the release.
    (F) If the appointed actuary chooses to add a paragraph briefly describing the assumptions that form the basis for the actuarial opinion.

(b) A statement of actuarial opinion issued in accordance with this section must contain all pertinent aspects of the language provided in this section. The language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary should use language that clearly expresses his or her professional judgment. The following language is that which in typical circumstances would be included in a statement of actuarial opinion in accordance with this section:

(1) The opening paragraph shall include an identification of the appointed actuary and a description of the appointed actuary's relationship to the company and his or her qualifications to sign the opinion. The opening paragraph of the actuarial opinion shall read as follows:
    (A) For a company actuary, "I, [name], am [title] of [company] and a member of the American Academy of Actuaries. I was appointed by, or by the authority of, the Board of Directors of said company to render this opinion as stated in the letter to the Commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion

and am familiar with the valuation requirements applicable to life and health insurance companies.".

(B) For a consulting actuary, "I, [name and title of actuary], am a member of the American Academy of Actuaries and am associated with the firm of [insert name of consulting firm]. I have been appointed by, or by the authority of, the Board of Directors of [name of company] to render this opinion as stated in the letter to the Commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies.".

(2) The scope paragraph must identify the subjects on which an opinion is to be expressed and describe the scope of the appointed actuary's work, including a tabulation delineating the reserves and related actuarial items that have been analyzed for asset adequacy and the method of analysis, and identify the reserves and related actuarial items covered by the opinion that have not been so analyzed. The scope paragraph shall include a statement such as, "I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state regulatory officials, as of December 31, [ ]. The following tabulation contains those reserves and related actuarial items which have been subjected to asset adequacy analysis":

Asset Adequacy Tested Amounts Reserves and Liabilities					
Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (a)(2)	Analysis Method (b)	Other Amount (3)	Total Amount (1) + (2) + (3) (4)
Aggregate Reserves for Life Policies and Contracts					
A. Life Insurance					
B. Annuities					
C. Supplementary Contracts Involving Life Contingencies					
D. Accidental Death Benefit					
E. Disability–Active					
F. Disability–Disabled					
G. Miscellaneous					
Total (Page __, Line __)					
Aggregate Reserves for Accident and Health Contracts					
A. Active Life Reserve					
B. Claim Reserve					
Total (Page __, Line __)					
Deposit Type Contracts					
1. Premiums and Other Deposit Funds					
1.1. Policyholder Premiums (Page __, Line __)					
1.2. Guaranteed Interest Contracts (Page __, Line __)					
1.3. Other Contract Deposit Funds (Page __, Line __)					
2. Supplementary Contracts Not Involving Life Contingencies (Page __, Line __)					
3. Dividend and Coupon Accumulations (Page __, Line __)					
Total					
Policy and Contract Claims for Life and Accident and Health Policies and Contracts, Part 1					
1. Life (Page __, Line __)					
2. Health (Page __, Line __)					
Total (Page __, Line __)					

Separate Accounts (Page __, Line __)					
TOTAL RESERVES					

IMR (Page __ Line __)	
AVR (Page __ Line __)	(c)

Notes:

(a) The additional actuarial reserves are the reserves established under section 5(e)(2) of this rule.

(b) The appointed actuary should indicate the method of analysis, determined in accordance with the standards for asset adequacy analysis referred to in section 5(d) of this rule, by means of symbols that should be defined in footnotes to the table.

(c) Allocated amount.

(3) The reliance paragraph shall describe those areas, if any, where the appointed actuary has deferred to other experts in developing data, procedures, or assumptions, for example, anticipated cash flows according to economic scenarios. The reliance paragraph shall include the following:

(A) If the appointed actuary has relied on other experts to develop certain portions of the analysis, the reliance paragraph shall include the statement:

"I have relied on [name], [title] for [e.g., 'anticipated cash flows from currently owned assets, including variations in cash flows according to economic scenarios' or 'certain critical aspects of the analysis performed in conjunction with forming my opinion'] as certified in the attached statement. I have reviewed the information relied upon for reasonableness.".

A statement of reliance on other experts shall be accompanied by a statement by each of such experts in the form prescribed by subsection (e).

(B) If the appointed actuary has examined the underlying asset and liability records, the reliance paragraph shall also include the statement, "My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic asset and liability records and such tests of the actuarial calculations as I considered necessary. I also reconciled the underlying basic asset and liability records to [exhibits and schedules listed as applicable] of the company's current annual statement.".

(C) If the appointed actuary has not examined the underlying records, but has relied upon data (for example, listings and summaries of policies in force and/or asset records) prepared by the company, the reliance paragraph shall include the statement,

"In forming my opinion on [specify reserves] I relied upon data prepared by [name and title of company officer certifying in-force records or other data] as certified in the attached statements. I evaluated that data for reasonableness and consistency. I also reconciled that data to [exhibits and schedules to be listed as applicable] of the company's current annual statement. In other respects, my examination included review of the actuarial assumptions and actuarial methods used and tests of the calculations I considered necessary.".

A statement of reliance on other experts shall be accompanied by a statement by each of such experts in the form prescribed by subsection (e).

(4) The opinion paragraph shall express the appointed actuary's opinion with respect to the adequacy of the supporting assets to mature the liabilities. The opinion paragraph shall include a statement, such as, "In my opinion the reserves and related actuarial values concerning the statement items identified above:

(A) are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;

(B) are based on actuarial assumptions which produce reserves at least as great as those called for in any contract provision as to reserve basis and method and are in accordance with all other contract provisions;

(C) meet the requirements of [state of domicile] insurance law and regulations and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;

(D) are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year end (with any exceptions noted below); or

(E) include provision for all actuarial reserves and related statement items which ought to be established.

The reserves and related items, when considered in light of the assets held by the company with respect to such reserves and

related actuarial items, including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts, make adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company.

The actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as Promulgated by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

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

The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion. The analysis of asset adequacy portion of this opinion should be viewed recognizing that the company's future experience may not follow the assumptions used in the analysis.

Signature of Appointed Actuary

Address of Appointed Actuary

Telephone Number of Appointed Actuary".

(c) The adoption for new issues or new claims or other new liabilities of an actuarial assumption, which differs from a corresponding assumption used for prior new issues or new claims or other new liabilities, is not a change in actuarial assumptions within the meaning of this section.

(d) If the appointed actuary is unable to form an opinion, then he or she shall refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, he or she shall issue an adverse or qualified actuarial opinion explicitly stating the reason or reasons for such opinion. This statement should follow the scope paragraph and precede the opinion paragraph.

(e) If the appointed actuary does not express an opinion as to the accuracy and completeness of the listings and summaries of policies in force and/or asset oriented information, there shall be attached to the opinion a statement similar to either of the following by a company officer or the accounting firm who prepared such underlying data:

(1) "I [name of officer], [title], of [name and address of company or accounting firm], hereby affirm that the listings and summaries of policies and contracts in force as of December 31, [ ], prepared for and submitted to [name of appointed actuary] were prepared under my direction and, to the best of my knowledge and belief, are substantially accurate and complete.

Signature of the Officer of the Company or Accounting Firm

Address of the Officer of the Company or Accounting Firm

Telephone Number of the Officer of the Company or Accounting Firm".

(2) "I, [name of officer], [title] of [name and address of company, accounting firm, or security analyst], hereby affirm that the listings, summaries, and analyses relating to data prepared for and submitted to [name of appointed actuary] in support of the asset oriented aspects of the opinion were prepared under my direction and, to the best of my knowledge and belief, are substantially accurate and complete.

Signature of the Officer of the Company, the Accounting Firm, or the Security Analyst

---

Address of the Officer of the Company, the Accounting Firm, or the Security Analyst

---

Telephone Number of the Officer of the Company, the Accounting Firm, or the Security Analyst".

(f) The commissioner may accept the valuation of a foreign insurer when that valuation meets the requirement applicable to a company domiciled in this state in the aggregate. As an alternative to the requirements of subsection (b)(4)(C), the commissioner may make one (1) or more of the following additional approaches available to the opining actuary:

(1) A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of

domicile] and the formal written standards and conditions of this state for filing an opinion based on the law of the state of domicile". If the commissioner chooses to allow this alternative, a formal written list of standards and conditions shall be made available. If a company chooses to use this alternative, the standards and conditions in effect on July 1 of a calendar year shall apply to statements for that calendar year, and they shall remain in effect until they are revised or revoked. If no list is available, this alternative is not available.

(2) A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and I have verified that the company's request to file an opinion based on the laws of the state of domicile has been approved and that any conditions required by the commissioner for approval of that request have been met". If the commissioner chooses to allow this alternative, a formal written statement of such allowance shall be issued no later than March 31 of the year it is first effective. Subsequent to that statement being issued, if a company chooses to use this alternative, the company shall file a request to do so, along with justification for its use, no later than April 30 of the year of the opinion to be filed. The request shall be deemed approved on October 1 of that year if the commissioner has not denied the request by that date.

(3) A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and I have submitted the required comparison as specified by this state", including the following:

(A) If the commissioner chooses to allow this alternative, a formal written list of products (to be added to the table in clause (B)) for which the required comparison shall be provided will be published. If a company chooses to use this alternative, the list in effect on July 1 of a calendar year shall apply to statements for that calendar year, and it shall remain in effect until it is revised or revoked. If no list is available, this alternative is not available.

(B) If a company desires to use this alternative, the appointed actuary shall provide a comparison of the gross nationwide reserves held to the gross nationwide reserves that would be held under NAIC codification standards. Gross nationwide reserves are the total reserves calculated for the total company in force business directly sold and assumed, indifferent to the state in which the risk resides, without reduction for reinsurance ceded. The information provided shall be at least:

(1) Product Type	(2) Death Benefit or Account Value	(3) Reserves Held	(4) Codification Reserves	(5) Codification Standard

(C) The information listed shall include all products identified by either the state of filing or any other states subscribing to this alternative.

(D) If there is no codification standard for the type of product or risk in force or if the codification standard does not directly address the type of product or risk in force, the appointed actuary shall provide detailed disclosure of the specific method and assumptions used in determining the reserves held.

(E) The comparison provided by the company is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

Notwithstanding this subsection, the commissioner may reject an opinion based on the laws and regulations of the state of domicile and require an opinion based on the laws of this state. If a company is unable to provide the opinion within sixty (60) days of the request or such other period of time determined by the commissioner after consultation with the company, the commissioner may contract an independent actuary at the company's expense to prepare and file the opinion. *(Department of Insurance; 760 IAC 1-57-8; filed May 16, 1997, 9:30 a.m.: 20 IR 2783; filed Oct 6, 2003, 5:15 p.m.: 27 IR 508, eff Dec 31, 2003; errata filed Dec 16, 2003, 1:30 p.m.: 27 IR 1575)*

760 IAC 1-57-9 Description of actuarial memorandum including an asset adequacy analysis

Authority: IC 27-1-12-10.1
Affected: IC 27-1-3.1; IC 27-1-12-10

Sec. 9. (a) In accordance with IC 27-1-12-10.1, the appointed actuary shall prepare a memorandum to the company describing the analysis done in support of his or her opinion regarding the reserves under an opinion issued pursuant to section 8 of this rule. The memorandum shall be made available for examination by the commissioner upon his or her request but shall be returned to the

company after such examination and shall not be considered a record of the insurance department or subject to automatic filing with the commissioner.

(b) In preparing the memorandum, the appointed actuary may rely on, and include as a part of his or her own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of section 5(b) of this rule, with respect to the areas covered in such memoranda, and so state in their memoranda.

(c) If the commissioner requests a memorandum and no such memorandum exists or if the commissioner finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board or the standards and requirements of this rule, the commissioner may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is required for review. The reasonable and necessary expense of the independent review shall be paid by the company but shall be directed and controlled by the commissioner.

(d) The reviewing actuary shall have the same status as an examiner under IC 27-1-3.1 for purposes of obtaining data from the company. The work papers and documentation of the reviewing actuary shall be retained by the commissioner; provided, however, that any information provided by the company to the reviewing actuary and included in the work papers shall be considered as material provided by the company to the commissioner and shall be kept confidential to the same extent as is prescribed by law with respect to other material provided by the company to the commissioner pursuant to IC 27-1-12-10 and IC 27-1-12-10.1. The reviewing actuary shall not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer under this rule for the current year or any one (1) of the preceding three (3) years.

(e) The appointed actuary shall prepare a regulatory asset adequacy issues summary, the contents of which are specified in subsection (g). The regulatory asset adequacy issues summary shall be submitted no later than March 15 of the year following the year for which a statement of actuarial opinion based on adequacy is required. The regulatory asset adequacy issues summary is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

(f) When an actuarial opinion is provided, the memorandum shall demonstrate that the analysis has been done in accordance with the standards for asset adequacy analysis referred to in section 5(d) of this rule and any additional standards under this rule. It shall specify the following:

(1) For reserves:

(A) product descriptions, including market description, underwriting and other aspects of a risk profile, and the specific risks the appointed actuary deems significant;

(B) source of liability in force;

(C) reserve method and basis;

(D) investment reserves;

(E) reinsurance arrangements;

(F) identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis; and

(G) documentation of assumptions to test reserves for:

(i) lapse rates (both base and excess);

(ii) interest crediting rate strategy;

(iii) mortality;

(iv) policyholder dividend strategy;

(v) competitor or market interest rate;

(vi) annuitization rates;

(vii) commissions and expenses; and

(viii) morbidity.

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

(2) For assets:

(A) portfolio descriptions, including a risk profile disclosing the quality, distribution, and types of assets;

(B) investment and disinvestment assumptions;

(C) source of asset data;

(D) asset valuation bases; and

(E) documentation of assumptions made for the following:

(i) default costs;

(ii) bond call function;

(iii) mortgage prepayment function;

(iv) determining market value for assets sold due to disinvestment strategy; and

(v) determining yield on assets acquired through the investment strategy.

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

(3) Analysis basis:

(A) methodology;

(B) rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;

(C) rationale for degree of rigor in analyzing different blocks of business;

(D) criteria for determining asset adequacy; and

(E) whether the impact of federal income taxes was considered and the method of treating reinsurance in the asset adequacy analysis.

(4) Summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis.

(5) Summary of results.

(6) Conclusion.

(g) The memorandum shall include a statement similar to, "Actuarial methods, considerations, and analysis used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum.".

(h) The regulatory asset adequacy issues summary required by subsection (e) shall state the name of the company for which it is being supplied and shall be signed and dated by the appointed actuary rendering the actuarial opinion. The regulatory asset adequacy issues summary shall include the following:

(1) Descriptions of the scenarios tested (including whether those scenarios are stochastic or deterministic) and the sensitivity testing done relative to those scenarios. If negative ending surplus results under certain tests in the aggregate, the actuary should describe those tests and the amount of additional reserve as of the valuation date which, if held, would eliminate the negative aggregate surplus values. Ending surplus values shall be determined by either extending the projection until the in force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in force.

(2) The extent to which the appointed actuary uses assumptions in the asset adequacy that are materially different than the assumptions used in the previous asset adequacy analysis.

(3) The amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion.

(4) Comments on any interim results that may be of significant concern to the appointed actuary.

(5) The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested.

(6) Whether the actuary has been satisfied that all options whether explicit or embedded, in any asset or liability (including, but not limited to, those affecting cash flows embedded in fixed income securities) and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

(Department of Insurance; 760 IAC 1-57-9; filed May 16, 1997, 9:30 a.m.: 20 IR 2787; filed Oct 6, 2003, 5:15 p.m.: 27 IR 512, eff Dec 31, 2003)

760 IAC 1-57-10 Additional considerations for analysis

Authority: IC 27-1-12-10.1

Affected: IC 27-1-12-10.1

Sec. 10. (a) The appointed actuary shall analyze only those assets held in support of the reserves that are the subject for specific analysis, hereafter called "specified reserves". A particular asset or portion thereof supporting a group of specified reserves

cannot support any other group of specified reserves. An asset may be allocated over several groups of specified reserves. The annual statement value of the assets held in support of the reserves shall not exceed the annual statement value of the specified reserves, except as provided in subsection (b). If the method of asset allocation is not consistent from year to year, the extent of its inconsistency should be described in the supporting memorandum.

(b) An appropriate allocation of assets in the amount of the Interest Maintenance Reserve (IMR), whether positive or negative, must be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the Asset Valuation Reserve (AVR); these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for in risk analysis and reserve support.

(c) The amount of the assets used for the AVR must be disclosed in the Table of Reserves and Liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets must be disclosed in the memorandum.

(d) Interest rate scenarios used in performing the asset adequacy analysis shall be as follows:

(1) For the purpose of performing the asset adequacy analysis required by this rule, the qualified actuary is expected to follow standards adopted by the Actuarial Standards Board; however, the appointed actuary must consider in the analysis the effect of at least the following interest rate scenarios:

(A) Level with no deviation.

(B) Uniformly increasing over ten (10) years at one-half percent (0.5%) per year and then level.

(C) Uniformly increasing at one percent (1%) per year over five (5) years and then uniformly decreasing at one percent (1%) per year to the original level at the end of ten (10) years and then level.

(D) An immediate increase of three percent (3%) and then level.

(E) Uniformly decreasing over ten (10) years at one-half percent (0.5%) per year and then level.

(F) Uniformly decreasing at one percent (1%) per year over five (5) years and then uniformly increasing at one percent (1%) per year to the original level at the end of ten (10) years and then level.

(G) An immediate decrease of three percent (3%) and then level.

For these and other scenarios that may be used, projected interest rates for a five (5) year Treasury Note need not be reduced beyond the point where the five (5) year Treasury Note yield would be at fifty percent (50%) of its initial level.

(2) The beginning interest rates may be based on:

(A) interest rates for new investments as of the valuation date similar to recent investments allocated to support the product being tested; or

(B) an outside index, such as Treasury yields, of assets of the appropriate length on a date close to the valuation date.

Whatever method is used to determine the beginning yield curve and associated interest rates should be specifically defined. The beginning yield curve and associated interest rates should be consistent for all interest rate scenarios.

(e) The appointed actuary shall retain on file, for at least seven (7) years:

(1) sufficient documentation so that it will be possible to determine the procedures followed;

(2) the analysis performed;

(3) the bases for assumptions; and

(4) the results obtained.

(Department of Insurance; 760 IAC 1-57-10; filed May 16, 1997, 9:30 a.m.: 20 IR 2787; filed Oct 6, 2003, 5:15 p.m.: 27 IR 514, eff Dec 31, 2003; errata filed Dec 16, 2003, 1:30 p.m.: 27 IR 1575)

Rule 58. Eligibility for Coverage from the Indiana Comprehensive Health Insurance Association

760 IAC 1-58-1 Authority

Authority: IC 27-8-10-7
Affected: IC 27-8-10-5.1

Sec. 1. This rule is adopted and promulgated pursuant to the authority granted by IC 27-8-10-7. *(Department of Insurance; 760 IAC 1-58-1; filed Mar 2, 1998, 8:30 a.m.: 21 IR 2389)*

760 IAC 1-58-2 Purpose and scope

Authority: IC 27-8-10-7
Affected: IC 27-8-10-5.1

Sec. 2. The purpose of this rule is to allow a federally eligible individual, as defined by the Health Insurance Portability and Accountability Act of 1996, to receive a policy of insurance through the Indiana Comprehensive Health Insurance Association. *(Department of Insurance; 760 IAC 1-58-2; filed Mar 2, 1998, 8:30 a.m.: 21 IR 2389)*

760 IAC 1-58-3 Definitions

Authority: IC 27-8-10-7
Affected: IC 27-8-10-5.1

Sec. 3. The following definitions apply to terms used throughout this rule:

(1) "Indiana resident" means a person who resides in Indiana on the date the person submits an application for an association policy.

(2) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(Department of Insurance; 760 IAC 1-58-3; filed Mar 2, 1998, 8:30 a.m.: 21 IR 2389)

760 IAC 1-58-4 Eligibility

Authority: IC 27-8-10-7
Affected: IC 27-8-10-5.1

Sec. 4. An Indiana resident is eligible for an association policy upon a showing that the resident is a federally eligible individual as defined by 42 U.S.C. 300gg-41(b) as added by sec 111(a) of P.L.104-191, the Health Insurance Portability and Accountability Act of 1996. *(Department of Insurance; 760 IAC 1-58-4; filed Mar 2, 1998, 8:30 a.m.: 21 IR 2389)*

760 IAC 1-58-5 General requirements

Authority: IC 27-8-10-7
Affected: IC 27-8-10-5.1

Sec. 5. A federally eligible individual who obtains an association policy shall not be subject to a preexisting condition exclusion. *(Department of Insurance; 760 IAC 1-58-5; filed Mar 2, 1998, 8:30 a.m.: 21 IR 2389)*

Rule 59. HMO Grievance Procedures

760 IAC 1-59-1 Authority

Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28; IC 27-13-10

Sec. 1. This rule is adopted and promulgated pursuant to the authority granted by IC 27-8-28-20, IC 27-13-10-13, and IC 27-13-35-1. *(Department of Insurance; 760 IAC 1-59-1; filed Sep 30, 1998, 2:17 p.m.: 22 IR 446, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2326)*

760 IAC 1-59-2 Purpose

Authority: IC 27-8-28-20; IC 27-13-10-13
Affected: IC 27-8-28-19; IC 27-13-8-2; IC 27-13-10

Sec. 2. The purpose of this rule is to prescribe the following for insurers and health maintenance organizations:

(1) The form for filing information with the commissioner, as required by IC 27-8-28-19 and IC 27-13-8-2(a).
(2) Requirements for notifying enrollees of grievance procedures.
(3) Requirements for filing, investigating, and resolving grievances and appeals.

(Department of Insurance; 760 IAC 1-59-2; filed Sep 30, 1998, 2:17 p.m.: 22 IR 446, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2326)

760 IAC 1-59-3 Definitions

Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28-3; IC 27-13-1-12; IC 27-13-1-32; IC 27-13-10-7

Sec. 3. The definitions in IC 27-8-28 and IC 27-13 shall apply for purposes of this rule, in addition to the following:

(1) "Enrollee", as defined in IC 27-13-1-12, includes "subscriber" as defined in IC 27-13-1-32 and "covered individual" as defined in IC 27-8-28-3.

(2) "Grievance" means the following:

(A) For a health maintenance organization and a limited service health maintenance organization, any dissatisfaction expressed by or on behalf of an enrollee of a health maintenance organization or a limited service health maintenance organization regarding the:

(i) availability, delivery, appropriateness, or quality of health care services;
(ii) handling or payment of claims for health care services; or
(iii) matters pertaining to the contractual relationship between:

(AA) an enrollee and a health maintenance organization or a limited service health maintenance organization; or
(BB) a group or individual contract holder and a health maintenance organization or a limited service health maintenance organization;

and for which the enrollee has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

(B) For an insurer, any dissatisfaction expressed by or on behalf of a covered individual regarding:

(i) a determination that a service or a proposed service is not appropriate or medically necessary;
(ii) a determination that a service or a proposed service is experimental or investigational;
(iii) the availability of participating providers;
(iv) the handling or payment of claims for health care services; or
(v) matters pertaining to the contractual relationship between a:

(AA) covered individual and an insurer; or
(BB) group policyholder and an insurer;

and for which the covered individual has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction.

(3) "Grievance procedures" means written procedures established and maintained by a health maintenance organization, a limited service health maintenance organization, or an insurer for filing, investigating, and resolving grievances and appeals.

(4) "Major population group" means a racial or ethnic group for whom English is not the primary language and whose members comprise at least ten percent (10%) of the health maintenance organization's enrollees.

(Department of Insurance; 760 IAC 1-59-3; filed Sep 30, 1998, 2:17 p.m.: 22 IR 447, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2327)

760 IAC 1-59-4 Reports

Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28-19; IC 27-13-8-2

Sec. 4. On or before March 1 of each year, an insurer, a health maintenance organization, and a limited service health maintenance organization must submit electronically to the department a grievance procedure report for the preceding calendar year on the form set forth in section 14 of this rule. A health maintenance organization and a limited service health maintenance

organization may submit the information required by IC 27-13-8-2(a)(2) and IC 27-13-8-2(a)(3) concurrent with this filing. *(Department of Insurance; 760 IAC 1-59-4; filed Sep 30, 1998, 2:17 p.m.: 22 IR 447, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2327)*

760 IAC 1-59-5 Grievance register

Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28; IC 27-13-10-3

Sec. 5. (a) An insurer, a health maintenance organization, and a limited service health maintenance organization shall maintain written records that document certain information about all grievances received during a calendar year (the grievance register).

(b) The grievance register shall contain, at a minimum, the following information for each grievance:

(1) A general description of the basis for the grievance using the categories in block 3 of the grievance procedures report set forth in section 14 of this rule.

(2) Date received.

(3) Date investigated or reviewed.

(4) Date resolved.

(5) Description of resolution.

(6) Date appeal, if any, was received.

(7) Date of appeals hearing or review.

(8) Date appeal was resolved.

(9) Description of resolution of the appeal.

(10) Name of enrollee and enrollee's representative, if any, who filed, or upon whose behalf was filed, the grievance.

(11) Names and titles of all persons who investigated, reviewed, and resolved the grievance.

(c) An insurer, a health maintenance organization, or a limited service health maintenance organization shall retain each grievance register until the commissioner has conducted an examination of the organization and adopted a final report of the examination that contains a review of the register for the calendar year covered by the grievance register. *(Department of Insurance; 760 IAC 1-59-5; filed Sep 30, 1998, 2:17 p.m.: 22 IR 447, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2327)*

760 IAC 1-59-6 Establishment of grievance procedures; filing with and review by commissioner

Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28-17; IC 27-13-2; IC 27-13-10; IC 27-13-34-8; IC 27-13-39-3

Sec. 6. (a) An insurer, a health maintenance organization, and a limited service health maintenance organization shall establish and maintain grievance procedures.

(b) A copy of the grievance procedures, including all forms used in filing and reviewing grievances, shall be included with any application for a certificate of authority submitted to the department.

(c) Any material modifications to the grievance procedures subsequent to the submission of the application shall be filed with the commissioner not more than fifteen (15) days after the adoption of the modification.

(d) The grievance procedures shall require the following:

(1) A health maintenance organization must provide written or oral acknowledgment of a grievance or appeal no more than three (3) business days after receipt. Insurers must provide written or oral acknowledgment of a grievance or appeal no more than five (5) business days after receipt. The acknowledgment must include the name, address, and telephone number of an individual to contact regarding the grievance and the date the grievance was filed.

(2) Investigation of any grievance or appeal in accordance with written procedures and the requirements of section 10 of this rule.

(3) Documentation of the substance of the grievance and all actions taken by the insurer or health maintenance organization regarding the grievance or appeal, including notification, acknowledgment, investigation, and resolution.

(4) Written notification to the enrollee of:

(A) resolution of the grievance or appeal;

(B) the right to appeal the resolution;

(C) information about how, when, and where to appeal the resolution; and

(D) the right to further remedies allowed by law, in the case of an appeal of a grievance resolution.

(e) The grievance procedures shall include procedures to assist enrollees and representatives of enrollees in filing grievances and appeals, including provisions for assistance to persons with literacy, language, physical, health, or other impediments.

(f) The grievance procedures shall include standards that meet the requirements of IC 27-8-28-17 or IC 27-13-10 and section 10 of this rule for timeliness in acknowledging, investigating, and resolving grievances and appeals and that accommodate the clinical urgency of the enrollee's situation. The standards for timeliness shall address:

(1) the likelihood of death, permanent injury, improvement, or deterioration of health status; and

(2) the ability to reach and maintain maximum function.

(g) The grievance procedures must require expedited review of a grievance or appeal if the time periods set forth in section 10 of this rule would seriously jeopardize the life or health of an enrollee or the enrollee's ability to reach and maintain maximum function.

(h) An HMO's grievance procedures must comply with the requirements of IC 27-13-39-3 with respect to any grievance regarding denial of coverage for a treatment, procedure, drug, or device on the grounds that it is experimental.

(i) The grievance procedures shall require and describe the process for the appointment of at least one (1) individual who has sufficient experience, knowledge, and training to appropriately resolve a grievance or appeal.

(j) The requirements of subsections (d) through (i) do not apply to a limited service health maintenance organization. *(Department of Insurance; 760 IAC 1-59-6; filed Sep 30, 1998, 2:17 p.m.: 22 IR 447, eff Jan 1, 1999; errata, 22 IR 759; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2328)*

760 IAC 1-59-7 Notice to enrollees

Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28; IC 27-13-7-5; IC 27-13-9-4; IC 27-13-10; IC 27-13-39

Sec. 7. (a) An insurer and a health maintenance organization shall provide the following to each enrollee:

(1) Information about health care services covered by the insurer or health maintenance organization, including the following:

(A) A description of covered services, including any services subject to a network restriction.

(B) A description of any limitations on payment for or coverage of health care services, including definitions of commonly used terms.

(C) Criteria used to determine whether to deny coverage.

(D) A description of exclusions from coverage.

(E) An explanation of any limitation on coverage for experimental treatments, procedures, drugs, or devices, including the following:

(i) A description of the process used to determine any limitation.

(ii) A description of the criteria the insurer or the health maintenance organization uses to determine whether a treatment, procedure, drug, or device is experimental.

(2) Information about where additional information on access to services can be obtained.

(3) Information about the insurer's or the health maintenance organization's grievance procedures, including the toll free telephone number described in section 8 of this rule.

(4) Information about the insurer's or the health maintenance organization's structure.

(5) Information about costs for which the enrollee is responsible.

(6) Information about financial incentives and disincentives given by the insurer or the health maintenance organization to providers.

(b) Except as provided in subsection (f), the information required by subsection (a) must be:

(1) included in or provided with the evidence of coverage required under IC 27-13-7-5 or any member handbook within the time periods set forth in subsection (f); and

(2) provided to any potential enrollee upon request.

(c) The information required by subsection (a)(3) shall be included on any notice to enrollees regarding the provision, limitation, or denial of health care services.

(d) The toll free telephone number shall be prominently displayed on any enrollment verification card.

(e) This subsection is applicable to health maintenance organizations only. A brief statement of an enrollee's right to file a grievance with the health maintenance organization, including the toll free telephone number, shall be posted by a participating provider in a conspicuous public location in each place where health care services are provided by or on behalf of the health maintenance organization. The notice shall be in bold face type at least one-half (½) inch in height. The statement must contain the following or substantially similar language: "We participate in the following health maintenance organizations: [list names of and toll free telephone numbers of participating HMOs]. If you have coverage through one (1) of these HMOs and have a complaint or grievance, you may call the HMO at its toll free number listed above. The HMO is required by law to try to resolve your complaint or grievance. You may also register a complaint with the Indiana Department of Insurance at 1-800-622-4461. The HMO cannot retaliate against you or your provider for making a complaint.".

(f) The information required by subsection (a) must be provided to enrollees not later than one hundred twenty (120) days after the effective date of this rule. During the period beginning one hundred twenty (120) days after the effective date of this rule and ending on the first renewal date of the enrollee's plan that occurs on or after the effective date of this rule, the information required by subsection (a) may be provided to enrollees in an addendum to or statement separate from the documents described in subsections (b) and (d). *(Department of Insurance; 760 IAC 1-59-7; filed Sep 30, 1998, 2:17 p.m.: 22 IR 448, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2329)*

760 IAC 1-59-8 Toll free telephone number

Authority: IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-13-9-4; IC 27-13-10-5

Sec. 8. (a) An insurer and a health maintenance organization shall establish a toll free telephone number through which grievances and appeals may be filed and information about grievance procedures obtained.

(b) An individual who is knowledgeable about the insurer's or the health maintenance organization's grievance procedures and any applicable state laws and regulations must be available to respond to calls received at the toll free telephone number at least forty (40) normal business hours per week. The toll free telephone number must be answered by an answering machine or similar device at all other times.

(c) Any messages left through the toll free telephone number must be returned on the following business day by a qualified individual.

(d) The toll free telephone number must accept grievances in English and the languages of the major population groups served by the health maintenance organization. *(Department of Insurance; 760 IAC 1-59-8; filed Sep 30, 1998, 2:17 p.m.: 22 IR 449, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2329)*

760 IAC 1-59-9 Filing grievances

Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28; IC 27-13-10

Sec. 9. (a) A grievance may be filed with an insurer or a health maintenance organization orally, including by telephone, or in writing, including by facsimile or electronic means of communication.

(b) A grievance may be filed with a limited service health maintenance organization, in writing, including by facsimile or electronic means of communication.

(c) A grievance is considered to be filed on the day and time it is first received orally or in writing by the insurer, health maintenance organization, or limited service health maintenance organization.

(d) A grievance may be filed by an enrollee, or a representative of an enrollee, including a health care provider acting on behalf of an enrollee. *(Department of Insurance; 760 IAC 1-59-9; filed Sep 30, 1998, 2:17 p.m.: 22 IR 449, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2330)*

760 IAC 1-59-10 Standards for timely review and resolution of grievances

Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28; IC 27-13-10-7; IC 27-13-10-8

Sec. 10. (a) Minimum standards for timely review and resolution of grievances filed with an insurer or a health maintenance organization are as follows:

(1) A health maintenance organization shall provide oral or written acknowledgment of a filed grievance to an enrollee not more than three (3) business days after the grievance is filed. An insurer shall provide oral or written acknowledgment of a filed grievance to an enrollee or an enrollee's representative not more than five (5) business days after the grievance is filed.

(2) A health maintenance organization shall resolve a grievance not more than twenty (20) business days after the grievance is filed. An insurer shall resolve a grievance not more than twenty (20) business days after the insurer receives all information reasonably necessary to complete the review.

(3) Written notification to an enrollee of the resolution of a grievance not more than five (5) business days after the resolution.

(4) The time period set forth in subdivision (2) may be extended if an insurer or a health maintenance organization is unable to resolve a grievance within the specified time period due to circumstances beyond the insurer's or the health maintenance organization's control. An enrollee must be notified in writing of the reason for the delay not more than nineteen (19) business days after the grievance is filed. The insurer or the health maintenance organization shall issue a written notification of the resolution of the grievance not more than ten (10) business days after the notification to the enrollee of the delay.

(b) As used in this rule, "circumstances beyond the insurer's or the health maintenance organization's control" means the following:

(1) The failure of a provider that is not a participating provider to provide within fifteen (15) days of the filing of the grievance information that is requested by the insurer or the health maintenance organization and is necessary to adequately review and investigate the grievance.

(2) The failure of an enrollee to provide additional information requested by the insurer or the health maintenance organization that is necessary to resolve the grievance within fifteen (15) days of the filing of the grievance.

(c) Minimum standards for timely review and resolution of grievance resolution appeals filed with an insurer or a health maintenance organization are as follows:

(1) Oral or written acknowledgment by a health maintenance organization to an enrollee of a filed appeal not more than three (3) business days after the appeal is filed. Oral or written acknowledgment by an insurer to a covered individual of a filed appeal not more than five (5) business days after the appeal is filed.

(2) Resolution of the appeal not more than forty-five (45) business days after the appeal is filed.

(3) Written notification to an enrollee of the resolution of an appeal not more than five (5) business days after the resolution.

(Department of Insurance; 760 IAC 1-59-10; filed Sep 30, 1998, 2:17 p.m.: 22 IR 449, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2330)

760 IAC 1-59-11 Grievance resolution notice

Authority: IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-13-10-7

Sec. 11. The written notification of resolution required by section 10(a) and 10(c) of this rule shall contain the following:

(1) A statement of the insurer's or the health maintenance organization's understanding of the enrollee's grievance.

(2) A description of the resolution reached by the insurer or the health maintenance organization stated in clear terms and the contract basis or medical rationale for the resolution stated in sufficient detail for the enrollee to respond further to the insurer's or the health maintenance organization's position.

(3) A reference to the evidence or documentation used as the basis for the resolution.

(4) A statement of the procedures governing an appeal, including how to file an appeal.

(5) In the case of a resolution of an appeal of a grievance resolution, a notice of the enrollee's right to further remedies allowed by law.

(6) The department, address, and telephone number through which an enrollee may contact a qualified representative to obtain more information about the resolution of the grievance or the right to and procedures governing an appeal or further remedies allowed by law.

(Department of Insurance; 760 IAC 1-59-11; filed Sep 30, 1998, 2:17 p.m.: 22 IR 450, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2330)

760 IAC 1-59-12 Appeal of a grievance resolution

Authority: IC 27-8-28; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28; IC 27-8-17; IC 27-13-10-8

Sec. 12. (a) The health maintenance organization shall appoint a panel of individuals who have sufficient experience, knowledge, and training to appropriately resolve an appeal. If the grievance involves the proposal, refusal, or delivery of a health care procedure, treatment, or service, the panel must include at least one (1) individual who:

(1) has knowledge in the medical condition, procedure, or treatment at issue;

(2) is in the same licensed profession as the health care provider who proposed, refused, or delivered the health care procedure, treatment, or service that is the basis of the underlying grievance; and

(3) is not involved, in any manner, in the matter that is the basis of the underlying grievance or have a direct business relationship with the enrollee or the health care provider who proposed, refused, or delivered the health care procedure, treatment, or service that is the basis of the underlying grievance.

(b) In the case of an appeal of a grievance described in section 3(2)(B)(i) or 3(2)(B)(ii) of this rule, an insurer shall appoint a panel of one (1) or more qualified individuals to resolve an appeal. The panel shall include one (1) or more individuals who:

(1) have knowledge of the medical condition, procedure, or treatment at issue;

(2) are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;

(3) are not involved in the matter giving rise to the appeal or in the initial investigation of the grievance; and

(4) do not have a direct business relationship with the covered individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.

(c) An insurer and a health maintenance organization shall require the panel to meet at a time during normal business hours and place convenient to an enrollee who wishes to appear before or otherwise communicate with the panel, to the extent reasonably possible. An insurer and a health maintenance organization shall notify an enrollee whose grievance is the subject of an appeal not less than seventy-two (72) hours prior to the meeting of the panel. The enrollee may waive the seventy-two (72) hour notice of the meeting of the panel. *(Department of Insurance; 760 IAC 1-59-12; filed Sep 30, 1998, 2:17 p.m.: 22 IR 450, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2331)*

760 IAC 1-59-13 Review (Repealed)

Sec. 13. *(Repealed by Department of Insurance; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2333)*

760 IAC 1-59-14 Grievance procedures report form

Authority: IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-13-8-2

Sec. 14. The form required by section 4(a) of this rule is the following:

GRIEVANCE PROCEDURES REPORT

NAME: _____

FOR REPORTING PERIOD January 1, ____ through December 31, ____

Block 1 REPORTING COMPANY INFORMATION

NAIC Group Code:	
Assumed business name(s):	
Address:	
General business telephone number:	
Grievance reporting - toll free number:	
Name, telephone number, and e-mail address of contact person for grievance procedures:	
Languages in which grievances may be filed:	

Total number of Indiana enrollees at beginning of reporting period:	
Total number of Indiana enrollees at end of reporting period:	
Service area (use applicable county codes; if the entire state, please indicate entire state rather than list all county codes):	

Block 2 GENERAL INFORMATION

Number of grievances filed		Number of appeals filed	
Number of grievances resolved		Number of appeals resolved	
Number of grievances resolved with Company position upheld		Number of appeals resolved with position upheld	
Number of grievances resolved with Company position overturned		Number of appeals resolved with Company position overturned	
Number of grievances pending		Number of appeals pending	
Time to resolve grievances (average number of days)		Time to resolve appeals (average number of days)	

INTERNAL GRIEVANCE AND APPEALS INFORMATION

Block 3 NOTE: A grievance should not be recorded in more than one (1) category.

Basis	Number Filed	Company Position Upheld? Yes (#): No (#):	Number Pending	Average Number Of Days To Resolve	Appealed ? Yes (#): No (#):	Company Position Upheld On Appeal? Yes (#): No (#):	Number Of Appeals Pending	Average Number Of Days To Resolve Appeals
DENIAL OR LIMITATION OF COVERED HEALTH CARE SERVICES								
Inpatient services								
Outpatient services								
Emergency services								
Mental or behavioral services								
Home health care								
Prescription drugs								
Equipment or supplies								
Laboratory services								
Experimental treatments								
Other services								
HEALTH CARE PROVIDERS (for HMOs, LSHMOs, and Insurers with Network plans)								
Quality of health care services								
No referral or expired referral								
Problem with particular provider not available								
Problem with number of providers available								
Problem with type of providers available								
Problem with provider location								
Problem getting appointment								
OTHER BASIS FOR GRIEVANCE								
Difficulty in enrolling/ other enrollment issues								

Problem with claim payment or handling								
Benefits limited or excluded								
Timeliness of decision making								
Other (attach additional sheets if necessary)								

Block 4 DESCRIPTION OF GRIEVANCE PROCEDURES

Please describe your grievance procedures. Attach additional sheets as necessary:

Block 5 DESCRIPTION OF APPEALS PROCEDURES

Please describe your appeals procedures. Attach additional sheets as necessary:

(Department of Insurance; 760 IAC 1-59-14; filed Sep 30, 1998, 2:17 p.m.: 22 IR 451, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2331)

760 IAC 1-59-15 Effective date

Authority: IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-13-10

Sec. 15. This rule takes effect on January 1, 1999. *(Department of Insurance; 760 IAC 1-59-15; filed Sep 30, 1998, 2:17 p.m.: 22 IR 452, eff Jan 1, 1999)*

Rule 60. Physician Specialty Classes

760 IAC 1-60-1 Authority

Authority: IC 34-18-5-2
Affected: IC 34-18-5-2

Sec. 1. This rule is adopted and promulgated pursuant to the authority granted by IC 34-18-5-2. *(Department of Insurance; 760 IAC 1-60-1; filed Oct 23, 1998, 2:45 p.m.: 22 IR 754)*

760 IAC 1-60-2 Purpose and scope

Authority: IC 34-18-5-2
Affected: IC 34-18-5-2

Sec. 2. The purpose of this rule is to publish a list of specialty classes for licensed physicians to be used in determining a physician's annual surcharge for participation in the Indiana Patient's Compensation Fund. *(Department of Insurance; 760 IAC 1-60-2; filed Oct 23, 1998, 2:45 p.m.: 22 IR 754)*

760 IAC 1-60-3 List of physician specialty classes

Authority: IC 34-18-5-2
Affected: IC 34-18-5-2

Sec. 3. The list of physician specialty classes required by IC 34-18-5-2 is as follows:

Indiana Department of Insurance
Patient's Compensation Fund
Physician Class Plan
Class 0

ISO Code	Specialty
80001	Resident Nonmoonlighting

80221	Resident Moonlighting (No ER)
80230	Aerospace Medicine
80231	General Preventive Medicine – No Surgery
80234	Pharmacology – Clinical
80236	Public Health
80240	Legal Medicine and Forensic Medicine
80248	Nutrition
80249	Psychiatry (Including Child)
80250	Psychoanalysis
80251	Psychosomatic Medicine
80254	Allergy
80256	Dermatology – No Surgery
80263	Ophthalmology – No Surgery
80266	Pathology – No Surgery

Class 1

ISO Code	Specialty
80233	Occupational Medicine
80235	Physical Medicine and Rehabilitation
80237	Diabetes – No Surgery
80238	Endocrinology – No Surgery
80239	Family Practice – No Surgery
80241	Gastroenterology – No Surgery
80242	General Practice – No Surgery
80243	Geriatrics – No Surgery
80244	Gynecology – No Surgery
80245	Hematology – No Surgery
80246	Infectious Disease – No Surgery
80247	Rhinology – No Surgery
80252	Rheumatology – No Surgery
80255	Cardiovascular Disease – No Surgery
80257	Internal Medicine – No Surgery
80258	Laryngology – No Surgery
80259	Neoplastic Disease – No Surgery
80260	Nephrology – No Surgery
80261	Neurology (Including Child) – No Surgery
80262	Nuclear Medicine
80264	Otology – No Surgery
80265	Otorhinolaryngology – No Surgery
80267	Pediatrics – No Surgery
80268	Physicians (Not Otherwise Classified) – No Surgery
80269	Pulmonary Disease – No Surgery
80420	Family Physicians – No Surgery

Class 2

ISO Code	Specialty
80223	Resident Moonlighting (with ER)
80253	Radiology – No Surgery
80280	Radiology – Minor Surgery
80282	Dermatology – Minor Surgery
80289	Ophthalmology – Minor Surgery
80292	Pathology – Minor Surgery

80425	Radiation Therapy – Not Otherwise Classified
80431	Shock Therapy

Class 3

ISO Code	Specialty
80109	Physicians – No Major Surgery
80114	Surgery – Ophthalmology
80132	Physicians (Not Otherwise Classified) – Minor Surgery
80172	Physician (Not Otherwise Classified) – No Major Surgery
80270	Rhinology – Minor Surgery
80271	Diabetes – Minor Surgery
80272	Endocrinology – Minor Surgery
80273	Family Practice – Minor Surgery
80274	Gastroenterology – Minor Surgery
80275	General Practice – Minor Surgery
80276	Geriatrics – Minor Surgery
80277	Gynecology – Minor Surgery
80278	Hematology – Minor Surgery
80279	Infectious Diseases – Minor Surgery
80281	Cardiovascular Disease – Minor Surgery
80283	Intensive Care Medicine – Minor Surgery
80284	Internal Medicine – Minor Surgery
80285	Laryngology – Minor Surgery
80286	Neoplastic Diseases – Minor Surgery
80287	Nephrology – Minor Surgery
80288	Neurology (Including Child) – Minor Surgery
80290	Otology – Minor Surgery
80291	Otorhinolaryngology – Minor Surgery
80293	Pediatrics – Minor Surgery
80294	Physicians (Not Otherwise Classified) – Minor Surgery
80421	Family Physicians (GP) – Minor Surgery – No OB
80422	Catheterization, Not Otherwise Classified
80424	Emergency Medicine – No Surgery

Class 4

ISO Code	Specialty
80000	Family Practice – with OB
80101	Broncho-Esophagology
80115	Surgery – Colon and Rectal
80117	Surgery – GP (Not Primarily Engaged in Surgery)
80145	Surgery – Urological
80151	Surgery – Anesthesiology
80163	Radiation Therapy – Employed Physicians or Surgeons with Major Surgery
80428	Physicians – Minor Invasive Procedures – Myelography
80434	Physicians – Minor Invasive Procedures – Lymphangiography
80437	Physicians – Minor Invasive Procedures – Acupuncture
80440	Physicians – Minor Invasive Procedures – Laparoscopy
80443	Physicians – Minor Invasive Procedures – Colonoscopy
80446	Physicians – Minor Invasive Procedures – Needle Biopsy
80449	Radiopaque Dye Injection

Class 5

ISO Code	Specialty

80102	Emergency Medicine – No Major Surgery
80103	Physicians – Surgery – Endocrinology
80104	Physicians – Surgery – Gastroenterology
80105	Physicians – Surgery – Geriatrics
80106	Surgery – Laryngology
80107	Physicians – Surgery – Neoplastic
80108	Physicians – Surgery – Nephrology
80158	Surgery – Otology
80159	Surgery – Otorhinolaryngology
80160	Physicians – Surgery – Rhinology
80419	Family or General Practice – Major Surgery

Class 6

ISO Code	Specialty
80141	Surgery – Cardiac
80143	Surgery – General Not Otherwise Classified
80155	Surgery – Plastic – Otorhinolaryngology
80156	Surgery – Plastic Not Otherwise Classified
80157	Surgery – Emergency Medicine
80166	Surgery – Abdominal
80167	Surgery – Gynecology
80169	Surgery – Hand
80170	Surgery – Head and Neck

Class 7

ISO Code	Specialty
80144	Surgery – Thoracic
80146	Surgery – Vascular
80150	Surgery – Cardiovascular Disease
80154	Surgery – Orthopedic
80171	Surgery – Traumatic

Class 8

ISO Code	Specialty
80152	Surgery – Neurology (Including Child)
80153	Surgery – Obstetrics/Gynecology
80168	Surgery – Obstetrics

(Department of Insurance; 760 IAC 1-60-3; filed Oct 23, 1998, 2:45 p.m.: 22 IR 754; filed Aug 6, 1999, 2:35 p.m.: 22 IR 3934; filed Apr 26, 2004, 2:00 p.m.: 27 IR 2729, eff Jul 1, 2004)

760 IAC 1-60-4 Doctors of osteopathy

Authority: IC 34-18-5-2
Affected: IC 34-18-5-2

Sec. 4. Doctors of osteopathy classified by ISO Codes 84*** shall be included in the same rating class as the corresponding doctor of medicine specialty identified by ISO Codes 80***. *(Department of Insurance; 760 IAC 1-60-4; filed Oct 23, 1998, 2:45 p.m.: 22 IR 756)*

760 IAC 1-60-5 Part-time and retired physicians

Authority: IC 34-18-5-2
Affected: IC 25-22.5-1-1.1

Sec. 5. (a) A physician who practices medicine on a part-time basis shall pay a reduced surcharge as follows:

(1) A physician who practices medicine ten (10) hours per week or less shall receive a credit equal to seventy-five percent (75%) of the surcharge amount.

(2) A physician who practices medicine more than ten (10) but less than twenty (20) hours per week shall receive a credit equal to fifty percent (50%) of the surcharge amount.

(b) Medical school faculty shall receive a credit equal to sixty-seven percent (67%) of the surcharge amount. As used in this subsection, "medical school faculty" means a physician engaged in research or teaching at a medical school as defined in IC 25-22.5-1-1.1(h). To be eligible for the credit, no more than thirty percent (30%) of the physician's time may be spent treating patients whose treatment is unrelated to the physician's duties at the medical school.

(c) Newly licensed physicians shall receive a credit equal to fifty percent (50%) of the surcharge amount during their first year of practice and twenty-five percent (25%) during their second year. For purposes of this subsection, a physician is considered newly licensed for two (2) years after completion of a residency program or a fellowship program in their medical specialty or the fulfillment of a military obligation in remuneration for medical school tuition.

(d) A retired physician shall pay an annual surcharge in the amount of five hundred dollars ($500).

(e) No more than one (1) credit may be applied to a physician in any policy year. *(Department of Insurance; 760 IAC 1-60-5; filed Oct 23, 1998, 2:45 p.m.: 22 IR 756; filed Aug 6, 1999, 2:35 p.m.: 22 IR 3936; filed Apr 26, 2004, 2:00 p.m.: 27 IR 2730, eff Jul 1, 2004)*

Rule 61. Viatical Settlements

760 IAC 1-61-1 Purpose and scope

Authority: IC 27-8-19.8-25; IC 27-8-19.8-26
Affected: IC 27-8-19.8-17

Sec. 1. (a) The purpose of this rule is to effectuate IC 27-8-19.8 by establishing minimum standards and disclosure requirements to be met by viatical settlement providers with respect to:

(1) viatical settlement contracts advertised, solicited, negotiated, or executed in Indiana; and

(2) licensing requirements for viatical settlement providers, brokers, and agents.

(b) Except as otherwise specifically provided, this rule applies to the following:

(1) Every person acting as a viatical settlement agent, broker, and provider as defined in IC 27-8-19.8-4.3, IC 27-8-19.8-4.5, and IC 27-8-19.8-5, respectively, on or after January 1, 1999.

(2) Every viatical settlement contract advertised, solicited, negotiated, or executed in Indiana on or after January 1, 1999. *(Department of Insurance; 760 IAC 1-61-1; filed Oct 20, 1999, 10:23 a.m.: 23 IR 577)*

760 IAC 1-61-2 Definitions

Authority: IC 27-8-19.8-25; IC 27-8-19.8-26
Affected: IC 27-8-19.8-17; IC 27-8-19.8-23

Sec. 2. In addition to the definitions in IC 27-8-19.8, the following definitions apply throughout this rule:

(1) "Affiliate of a specific person" means a person who directly, or indirectly through one (1) or more intermediaries:

(A) controls;

(B) is controlled by; or

(C) is under common control with;

the person specified.

(2) "Catastrophic or life threatening illness or condition" means an illness, disease, or condition that can reasonably be expected to result in death in thirty-six (36) months or less.

(3) "Commissioner" means the commissioner of the department of insurance.

(4) "Disclosure form" means a document containing the disclosures required by IC 27-8-19.8-23 and this rule.

(5) "Life expectancy" means the mean of the number of months the individual insured under the life insurance policy to be viaticated can be expected to live as determined by the viatical settlement provider or a third party considering medical records and appropriate experiential data.

(6) "Net death benefit" means the amount of the life insurance policy or certificate to be viaticated less any outstanding debts or liens.

(7) "Viatical settlement broker" means a person that represents only the viator and, for a fee, commission, or other valuable consideration, solicits, offers, or attempts to negotiate a viatical settlement contract between a viator and one (1) or more viatical settlement providers.

(Department of Insurance; 760 IAC 1-61-2; filed Oct 20, 1999, 10:23 a.m.: 23 IR 577)

760 IAC 1-61-3 Licensure and regulation of viatical settlement agents and brokers

Authority: IC 27-8-19.8-26
Affected: IC 27-1-15.5-2; IC 27-8-19.8

Sec. 3. (a) No person may act as a viatical settlement agent or a viatical settlement broker unless the person:

(1) is licensed as a life insurance agent under IC 27-1-15.5; and

(2) has filed with the commissioner a declaration that contains:

(A) a statement the person intends to act as a viatical settlement broker or a viatical settlement agent in Indiana;

(B) a list of the states in which the person is or has ever been licensed to act as, is acting as, or has acted as a viatical settlement agent or broker and the current status of any such license, including if the license has ever been revoked or suspended; and

(C) a report describing the nature and status of:

(i) any formal or informal disciplinary or other regulatory action by the federal government or any level of government in any state; or

(ii) any administrative, civil, or criminal action;

that is pending or has been taken against the applicant with respect to the business of viatical settlements or life insurance.

(b) A viatical settlement broker is deemed to represent only the viator's interests and shall owe a fiduciary duty to the viator to act according to the viator's instructions and in the viator's best interests.

(c) A viatical settlement broker may not seek or obtain any compensation from the viator without the written agreement of the viator obtained before the broker performs any services in connection with the viatical settlement transaction.

(d) A viatical settlement agent is deemed to represent only the viatical settlement provider. A viatical settlement agent may not seek or obtain any compensation from the viator in connection with the viatical settlement transaction.

(e) In addition to the disclosure requirement set forth in subsection (a), a person who acts as a viatical settlement agent or broker shall comply with and be subject to all provisions of Indiana insurance law and rules applicable to a life insurance agent as defined in IC 27-1-15.5-2. *(Department of Insurance; 760 IAC 1-61-3; filed Oct 20, 1999, 10:23 a.m.: 23 IR 578)*

760 IAC 1-61-4 Licensure of viatical settlement providers

Authority: IC 27-8-19.8-10
Affected: IC 4-21.5-3; IC 27-8-19.8-5

Sec. 4. (a) No person shall act as a viatical settlement provider unless the person has first obtained a license from the commissioner.

(b) An application for licensing as a viatical settlement provider must be submitted on an application form that may be obtained from the department of insurance at 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204. The application form is adopted by reference.

(c) A licensing fee in the amount of one thousand dollars ($1,000) shall accompany the completed application form.

(d) The application for license as a viatical settlement provider shall furnish all of the applicable information as follows:

(1) The name, address, and organizational structure of the applicant.

(2) Certified copies of the applicant's organization documents, including, but not limited to:

(A) articles of incorporation and any amendments thereto; and

(B) a certificate of incorporation and any amendments thereto.

(3) The identity of all of the following:

(A) Stockholders holding ten percent (10%) or more of the voting securities.
(B) Investors holding a ten percent (10%) or greater interest.
(C) Partners.
(D) Corporate officers.
(E) Trustees.
(F) If an association, all of the members.
(G) Any affiliates, together with a chart showing the relationship of the applicant to all affiliates. Any affiliate that is an insurance company licensed in Indiana shall be identified as such.

(4) Biographical affidavits of all of the following:
(A) Officers.
(B) Directors.
(C) Stockholders holding ten percent (10%) or more voting securities.
(D) Investors holding ten percent (10%) or greater interest.
(E) Partners.
(F) Trustees.
(G) Members, if an association.

(5) A list of states in which the viatical settlement provider is licensed on the date of application, a copy of each license, and a list of the states in which the viatical settlement provider is or has ever engaged in business as a viatical settlement provider.

(6) A list of all licenses from any level of federal government or government of any state applied for by or currently or previously held by the applicant, its officers, directors, trustees, stockholders holding ten percent (10%) or more of voting securities, investors holding a ten percent (10%) or greater interest, partners, or members (if an association), and a statement showing the current status of any such license, including whether it has ever been denied, revoked, or suspended.

(7) A report stating whether any formal or informal regulatory action by any level of government of any state or the federal government, including the Securities and Exchange Commission, has been taken or is pending against the applicant or its officers, directors, trustees, stockholders holding ten percent (10%) or more of voting securities, investors holding a ten percent (10%) or greater interest, partners, or members (if an association), and the status of the action.

(8) A report stating whether any criminal or civil action involving or alleging an offense that includes fraudulent acts or breach of contract has been taken or is pending against the applicant or its officers, directors, trustees, stockholders holding ten percent (10%) or more of voting securities, investors holding a ten percent (10%) or greater interest, partners, or members (if an association), and the status of the action.

(9) A copy of the applicant's most recent financial statement. A financial statement, for purposes of this rule, consists of a financial statement that is compiled in a manner consistent with generally accepted accounting principles (GAAP) and is accompanied by either an opinion by an independent accounting firm or a statement by an officer of the applicant, representing that the financial statement was prepared in a manner consistent with GAAP and accurately reflects the financial condition of the applicant.

(10) Copies of any documents filed by the applicant with the Securities and Exchange Commission and any state securities regulator.

(11) A detailed plan of operations for the applicant's business, including, but not limited to, information regarding or identifying the following items:
(A) Escrow accounts and banks.
(B) Advertising and agents, brokers, or other distribution system to be used.
(C) Marketing techniques to be used.
(D) Market training program.
(E) Entities with whom the applicant will contract for services in connection with the acquisition, pricing, and servicing of viatical settlement contracts.

(12) Such other information as the commissioner reasonably may require.

(e) A viatical settlement provider must possess net worth in the amount of not less than one hundred fifty thousand dollars ($150,000) to qualify for and maintain its license. For purposes of this subsection, in computing capital, the value of viaticated policies shall not be included.

(f) A viatical settlement provider may obtain financing for the execution, acquisition, or retention of a viatical settlement

contract only:

(1) through the services of an individual licensed to sell investments in viatical settlement contracts under applicable state laws; or

(2) from an institutional lender, insurance company, or reinsurer whose sole activity related to the transaction is providing funds to effect the viatical settlement and who has an agreement in writing with the viatical settlement provider to finance viatical settlement contracts.

(g) A viatical settlement provider shall report any material change in the information in the application or renewal form referred to in this section and section 5 of this rule, including any change of a residential or business address, not later than the thirtieth day after the date on which the change takes effect.

(h) The application process shall be as follows:

(1) The department of insurance shall have thirty (30) days after receipt of an application to determine whether the application is complete. If an application is not complete, the department of insurance will give the applicant written notice of the required information necessary to complete the application. The department shall take no further action on the application until the required information is submitted.

(2) The department of insurance shall have thirty (30) days from the date the application is determined to be complete under subdivision (1) to process the application and approve or deny it.

(i) If the commissioner denies an application for a license, the commissioner shall notify the applicant and advise the applicant in writing of the reasons for the denial of the license. Not later than sixty (60) days after receiving a notice from the commissioner under this subsection, the applicant may make written demand upon the commissioner for a hearing to determine the reasonableness of the commissioner's action. Such hearing shall be held within thirty (30) days from the date of receipt of the written demand of the applicant and shall be conducted in accordance with IC 4-21.5-3. *(Department of Insurance; 760 IAC 1-61-4; filed Oct 20, 1999, 10:23 a.m.: 23 IR 578; errata filed Dec 9, 1999, 1:05 p.m.: 23 IR 814)*

760 IAC 1-61-5 Renewal and maintenance of viatical settlement provider license

Authority: IC 27-8-19.8-26
Affected: IC 4-21.5-3; IC 27-8-19.8-15

Sec. 5. (a) A viatical settlement provider must apply to the department of insurance for a license renewal on or before June 1 of each year, commencing June 1, 2000. A renewal application may be obtained from the department of insurance at the address listed in section 4(b) of this rule. The renewal application is hereby adopted by reference.

(b) A renewal fee in the amount of five hundred dollars ($500) must accompany the renewal application.

(c) If a complete renewal application and the renewal fee are received by the department of insurance on or before June 1 of each year, the provider may continue to operate under its current license until the renewal is denied or issued by the department of insurance.

(d) If a complete renewal application and fee are not received on or before June 1, the license shall terminate automatically on July 1. A licensee may not act as a viatical settlement provider until the department issues the license renewal.

(e) If a complete renewal application and fee are not received on or before December 31 of the year that a license terminates pursuant to subsection (d), a viatical settlement provider must submit a new application and application fee pursuant to section 4 of this rule for a viatical settlement provider license.

(f) If the commissioner denies a renewal application for a license, the commissioner shall notify the applicant and advise the applicant in writing of the reasons for the denial of the renewal of the license. Not later than sixty (60) days after receiving a notice from the commissioner under this subsection, the applicant may make written demand upon the commissioner for a hearing to determine the reasonableness of the commissioner's action. Such hearing shall be held within thirty (30) days from the date of receipt of the written demand of the applicant and shall be conducted in accordance with IC 4-21.5-3.

(g) A viatical settlement provider must renew and maintain a license until either of the following events occurs:

(1) The date the viatical settlement provider properly assigns, sells, or otherwise transfers to another viatical settlement provider licensed in this state any viatical settlement contracts held by the provider that have not matured.

(2) The date that the last viatical settlement contract has matured.

(h) If the license of a viatical settlement provider who has contracts that have not yet matured is denied, suspended, revoked, or terminated, the provider shall appoint another viatical settlement provider licensed in Indiana to make all inquiries to the viator,

or the viator's designee, regarding health status of the viator or any other matters. *(Department of Insurance; 760 IAC 1-61-5; filed Oct 20, 1999, 10:23 a.m.: 23 IR 580; errata filed Dec 9, 1999, 1:05 p.m.: 23 IR 814)*

760 IAC 1-61-6 Requirements for viatical settlement contracts

Authority: IC 27-8-19.8-10; IC 27-8-19.8-26
Affected: IC 27-8-19.8-21; IC 27-8-19.8-24.2

Sec. 6. The following requirements apply to any viatical settlement contract that will be advertised, solicited, negotiated, or executed in Indiana:

(1) The form of contract or any amendment to it shall not be used until it is filed with and approved by the commissioner.

(2) The contract shall require payment in a lump sum equal to the full amount of the proceeds to a trust or escrow account in a state or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation. Payment into the escrow account shall be made immediately upon receipt of a signed viatical settlement contract. A trustee or escrow agent independent of the parties to the viatical settlement contract shall manage the account. The proceeds shall be paid to the viator by wire transfer to the account of the viator, by certified check, or by cashier's check, in accordance with the time periods set forth in IC 27-8-19.8-24.2(b).

(3) The contract shall contain the following rescission provisions:

(A) It shall allow unconditional rescission by the viator in accordance with time periods no less favorable than those set forth in IC 27-8-19.8-21(b)(2).

(B) The rescission provision shall be prominently displayed on the first page of the contract and shall set forth the method for giving notice of rescission. If notice of rescission is given by mail, it shall be deemed to be given when deposited in the United States mail, first class postage prepaid.

(C) It shall provide that if the insured dies during the period of time allowed for rescission, the contract will be automatically rescinded, subject to repayment of all proceeds to the viatical settlement provider.

(4) If a viatical settlement provider enters into a viatical settlement contract that allows the viator to retain an interest in the policy that is being viaticated, the viatical settlement contract shall contain the following provisions:

(A) A provision that the viatical settlement provider will effect the transfer of the amount of the death benefit only to the extent or portion of the amount viaticated. The insurance company shall pay benefits in excess of the amount viaticated directly to the viator's beneficiary.

(B) A provision that the viatical settlement provider will, upon acknowledgment of the completion of the assignment or transfer of the life insurance policy by its issuing company, either:

(i) advise the viator in writing that the insurance company has confirmed, in writing, the viator's nonviaticated interest in the policy; or

(ii) send to the viator a copy of the document sent from the insurance company to the viatical settlement provider that acknowledges the viator's nonviaticated interest in the policy.

(C) A provision that apportions the premiums to be paid by the viatical settlement provider and the viator. The viatical settlement contract may specify that all premiums shall be paid by the viatical settlement provider. The contract may also require that the viator reimburse the viatical settlement provider for the premiums attributable to the retained interest.

(5) With respect to policies containing a provision for double or additional indemnity for accidental death, the contract shall provide that the additional payment shall remain payable to the beneficiary last named by the viator prior to entering into the viatical settlement contract, or to such other beneficiary, other than the viatical settlement provider, as the viator may thereafter designate, or in the absence of a beneficiary, to the estate of the viator.

(Department of Insurance; 760 IAC 1-61-6; filed Oct 20, 1999, 10:23 a.m.: 23 IR 580)

760 IAC 1-61-7 Disclosure forms

Authority: IC 27-8-19.8-26
Affected: IC 27-8-19.8-23; IC 27-8-19.8-24.9

Sec. 7. The following requirements apply to each disclosure form that will be used in connection with a viatical settlement

contract that is negotiated or executed in Indiana:

(1) The disclosure form shall be provided to the viator prior to the date the viator signs the viatical settlement contract.

(2) The disclosures required by IC 27-8-19.8-23 shall be prominently displayed.

(3) The disclosure required by IC 27-8-19.8-23(7) shall specifically address at least the following rights and benefits if available under the insurance policy to be viaticated:

(A) Guaranteed insurability options.

(B) Accidental death or accidental death and dismemberment benefits.

(C) Disability income or loss of income protection.

(D) Conversion rights.

(E) Waiver of premium benefits.

(F) Family, spousal, or children's riders or benefits, and any other comparable coverage for a life other than the insured's.

(4) The disclosure form shall set forth the procedures for contacts with the insured in compliance with IC 27-8-19.8-24.9. The disclosure form shall contain a statement that contacts for the purposes of determining the health status of the insured must be made by mail unless the parties agree to another method. If the insured agrees to contact by a method other than mail, the alternative method or methods of contact must be included in the contract.

(5) The disclosure form shall contain the following or substantially similar language, "All medical, financial, and personal information solicited or obtained by a viatical settlement agent, broker, or provider about a viator and an insured, including the identity of the viator and insured and the identity of their family members or significant other, is confidential. The information shall not be disclosed to any person unless disclosure is:

(A) necessary and the viator and insured have provided written consent to the disclosure;

(B) provided in response to an investigation or examination by the commissioner or other governmental officer or agency; or

(C) in connection with a transfer of the contract or policy to another licensed viatical settlement provider or to an entity that provides financing to effect the contract under a written agreement with a licensed viatical settlement provider.".

(6) The disclosure form shall contain the following or substantially similar language: "Your insurance policy provides financial protection to your beneficiaries. If you sell your policy to a viatical settlement provider, your beneficiaries will no longer have that protection. Before you sell your policy, you should consider whether that protection is needed. Other financial options may be available to you. Consult your financial advisor or insurance company for more information.".

(7) The viatical settlement provider must keep a copy of each disclosure statement used in connection with each executed viatical settlement contract. The provider must retain any disclosure statements and signed affidavits for at least five (5) years after the death of the insured.

(Department of Insurance; 760 IAC 1-61-7; filed Oct 20, 1999, 10:23 a.m.: 23 IR 581)

760 IAC 1-61-8 Reporting requirements

Authority: IC 27-8-19.8-26
Affected: IC 5-24-3-4; IC 27-8-19.8-17

Sec. 8. On or before March 1 of each calendar year, each viatical settlement provider licensed in Indiana shall make a report of all viatical transactions for the previous calendar year where the viator is a resident of Indiana or was a resident of Indiana at the time the contract was executed and for all states in the aggregate containing the following information:

(1) The following for each viatical settlement contract executed or acquired during the reporting period:

(A) Date of viatical settlement contract.

(B) Life expectancy of the insured at the time of contract, in months.

(C) Face amount of the policy viaticated.

(D) Net death benefit viaticated.

(E) Estimated total premiums to keep the policy in force for life expectancy.

(F) Net amount paid to viator.

(G) Source of policy:

(i) A-agent;

(ii) B-broker;
(iii) D-direct purchase; or
(iv) SM-secondary market.

(H) Type of coverage:
(i) I-individual; or
(ii) G-group.

(I) Within the contestable or suicide period, or both, at the time of viatical settlement (yes or no).

(J) Primary International Classification of Diseases (ICD) diagnosis code, in numeric format, as defined by the international classification of diseases, as most recently published by the United States Department of Health and Human Services.

(K) Type of funding:
(i) I-institutional; or
(ii) P-private.

(L) A copy of the pricing memorandum described in section 9 of this rule. At the time of submission of the pricing memorandum or any subsequent supporting documentation, the viatical settlement provider may request the commissioner to withhold that material from public inspection in order to preserve trade secrets in accordance with IC 5-24-3-4. Each page covered by such request shall be clearly marked "confidentiality requested", and all pages so marked shall be placed in a separate envelope.

(2) The following for each viatical settlement contract where death has occurred during the reporting period:
(A) Date of viatical settlement contract.
(B) Life expectancy of the insured at the time of contract, in months.
(C) Net death benefit collected.
(D) Total premiums paid to maintain the policy (or indicate WP–waiver of premium or NA–not applicable).
(E) Net amount paid to viator.
(F) Primary International Classification of Diseases (ICD) diagnosis code, in numeric format, as defined by the international classification of diseases, as most recently published by the United States Department of Health and Human Services.
(G) Date of death.
(H) Amount of time between the date of contract and the date of death, in months.
(I) Difference between the number of months that passed between the date of the contract and the date of death and the life expectancy, in months, as determined by the reporting company.
(J) Date policy was issued to viator.

(3) Name and address of each viatical settlement agent and broker through whom the reporting company purchased a policy from a viator who resided in Indiana at the time of the contract.

(4) Number of policies reviewed and rejected.

(5) Number of policies purchased in the secondary market as a percentage of total policies purchased.

(Department of Insurance; 760 IAC 1-61-8; filed Oct 20, 1999, 10:23 a.m.: 23 IR 582)

760 IAC 1-61-9 Standards for evaluation of reasonable payments

Authority: IC 27-8-19.8-25; IC 27-8-19.8-26
Affected: IC 27-8-19.8-25

Sec. 9. (a) A viatical settlement provider shall not enter into a viatical settlement that provides a payment to the viator that is unreasonable or unjust. In determining whether a payment is unreasonable or unjust, the commissioner may consider relevant factors, including any of the following:

(1) The life expectancy of the viator.

(2) The applicable rating by a rating service generally recognized in the insurance industry, regulators, and consumer groups of the insurance company that issued the viaticated policy.

(3) The prevailing discount rates in the viatical settlement market in this state, or, if insufficient data is available for Indiana, the prevailing rates nationally or in other states that maintain this data.

(b) A viatical settlement provider shall prepare and maintain a pricing memorandum providing a description of the method and assumptions used in determining the value to be paid to viators. The memorandum shall include a description, which may use reasonable ranges, of the following:

(1) The procedure used to determine the insured's life expectancy, including medical, evaluation, and use of health care professionals in such evaluation.

(2) The portion of the discount (difference between the death benefit of the viaticated policy or certificate and the proceeds paid by the viatical settlement provider to the viator) due to market value interest rate (current value of money) and how this interest rate is determined.

(3) The portion of the discount due to agent or broker compensation paid by the viatical settlement provider.

(4) The portion of the discount that is the viatical settlement provider's operating costs in connection with viatical settlement contracts, including acquisition and maintenance cost and risk charge.

(5) The portion of the discount due to other overhead costs and profit margin.

(6) The effect, if any, that policy loans, surrender charges, and the net cash surrender value in the insurance plan have on the pricing determination.

(7) How provision is made in the settlement determination for future insurance policy premiums, dividends, or excess amounts, if any.

(8) What provisions, if any, are made in the settlement determination for supplemental insurance benefits or riders.

(Department of Insurance; 760 IAC 1-61-9; filed Oct 20, 1999, 10:23 a.m.: 23 IR 582; errata filed Dec 9, 1999, 1:05 p.m.: 23 IR 814)

760 IAC 1-61-10 Miscellaneous

Authority: IC 27-8-19.8-26
Affected: IC 27-8-19.8

Sec. 10. (a) A viatical settlement provider, agent, or broker shall not discriminate:

(1) in the solicitation or making of viatical settlements on the basis of race, age, sex, national origin, creed, religion, occupation, marital or family status, or sexual orientation; or

(2) between viators with dependents and without dependents.

(b) A viatical settlement provider, agent, or broker shall not pay or offer to pay any finder's fee, commission, or other compensation to any insured's physician, or to an attorney, accountant, or other person providing medical, legal, financial planning, or social services to the viator, or to any other person acting as an agent of the viator with respect to the viatical settlement.

(c) A viatical settlement provider shall not act also as a viatical settlement broker in the same viatical settlement, whether entitled to collect a fee, commission, or other compensation in the transaction.

(d) A viatical settlement provider shall not knowingly solicit investors who have treated or have been asked to treat the illness, disease, or condition of the insured whose coverage would be the subject of the investment.

(e) A viatical settlement agent, broker, or provider shall not disclose patient identifying information to any person, except in either of the following cases:

(1) With the written consent of the viator and insured obtained prior to the disclosure of the information. The written consent must refer to the particular disclosure to be made and must be retained by the agent, broker, or provider for at least five (5) years after receipt.

(2) In response to a subpoena provided that the viatical settlement agent, broker, or provider shall notify the viator and the insured of the existence of the subpoena in writing at the viator's and the insured's last known addresses within five (5) business days after receiving notice of the subpoena.

(f) The following standards shall apply to any advertising regarding viatical settlement contracts:

(1) Advertising related to the viatical settlement shall be truthful and not misleading by fact or implication.

(2) If the advertiser emphasizes the speed with which the viatication will occur, the advertising must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

(3) If the advertising emphasizes the dollar amounts available to viators, the advertising shall disclose the average purchase price as a percent of face value obtained by viators contracting with the advertiser during the previous six (6) months.

(Department of Insurance; 760 IAC 1-61-10; filed Oct 20, 1999, 10:23 a.m.: 23 IR 583)

760 IAC 1-61-11 Insurance company practices

Authority: IC 27-8-19.8-26
Affected: IC 27-8-19.8

Sec. 11. (a) Life insurance companies authorized to do business in Indiana shall respond to a request for verification of coverage from a viatical settlement provider, agent, or broker within thirty (30) calendar days of the date a request is received, subject to the following conditions:

(1) A current authorization consistent with applicable law, signed by the policy owner or certificate holder, accompanies the request.

(2) In the case of an individual policy, submission of a form substantially similar to the standardized viatical settlement verification of coverage for individual policies set forth in section 12(a) of this rule, which has been completed by the viatical settlement provider, broker, or agent.

(3) In the case of group insurance coverage, submission of a form substantially similar to the standardized viatical settlement verification of coverage for group policies set forth in section 12(b) of this rule, which has been completed by the following:

(A) The viatical settlement provider, broker, or agent.

(B) The group policyholder, to the extent the information is available to the policyholder.

(b) A life insurance company and a viatical settlement provider, broker, or agent may use a verification of coverage form different from the form set forth in section 12(a) or 12(b) of this rule if the alternative form has been mutually agreed upon in writing prior to the submission of the request for verification of coverage.

(c) A life insurance company may not charge a fee for responding to a request for verification of coverage from a viatical settlement provider, broker, or agent in compliance with this section in excess of any usual and customary charges to policyholders, certificate holders, or insureds for similar services.

(d) A life insurance company may send an acknowledgment of receipt of a request for verification of coverage to the policyholder or certificate holder and, where the policyholder or certificate holder is other than the insured, to the insured. The acknowledgment may contain a general description of any accelerated death benefit that is available under a provision of or rider to the life insurance contract. *(Department of Insurance; 760 IAC 1-61-11; filed Oct 20, 1999, 10:23 a.m.: 23 IR 583; errata filed Dec 9, 1999, 1:05 p.m.: 23 IR 814)*

760 IAC 1-61-12 Insurance coverage verification forms

Authority: IC 27-8-19.8-26
Affected: IC 27-8-19.8

Sec. 12. (a) The form for standardized viatical settlement verification of coverage for individual policies is as follows:

VERIFICATION OF COVERAGE FOR INDIVIDUAL POLICIES

Section One:

(To be Completed by the Viatical Settlement Provider, Broker, or Agent)

Insurance Company: _____ Name of Policyowner: _____

Policy Number: _____ Owner's Social Security Number: _____

Name of Insured: _____ Policyowner's Address: _____

Street

Insured's date of birth: _____ _____

City/State

Please provide the information requested in Section Two (below) with regard to the policy identified above and in accordance with the attached authorization.

In addition, please provide the forms checked below which are available from your company to complete a viatical settlement transaction:

☐ Absolute Assignment/Change of Ownership/Viatical Assignment Form
☐ Change of Beneficiary
☐ Release of Irrevocable Beneficiary (if applicable)
☐ Waiver of Premium Claim Form
☐ Disability Waiver of Premium Approval Letter

Date

Signature of a representative of Viatical Settlement Provider, Broker, or Agent

Full name and address of Viatical Settlement Provider, Broker, or Agent

Section Two:
(To be Completed by the Life Insurance Company)
1) Face amount of policy: $ _____
2) Original date of issue: ___/___/____ *(Month/Date/Year)*
3) Was face amount increased after original issue date?
☐ no ☐ yes
a) If yes, when: ____/____/____ *(Month/Date/Year)*
4) Type of Policy:____ *(Term/Whole Life/Universal Life/Variable Life)*
5) Is policy participating? ☐ no ☐ yes
a) If yes, what is current dividend election?_____
6) Current net death benefit: ____ *(Enter full amount payable, including any additional insurance and/or dividends accumulated at interest, minus policy loans, outstanding interest on policy loans, and/or accelerated death benefits paid)*
7) a) Current cash value: $ _____ *(Enter full amount, including cash value of any additional insurance and/or dividends accumulated at interest, minus policy loans and outstanding interest on policy loans)*
b) Currently surrender value: $ _____
8) Terms of policy loans:
a) Amount of policy loans: $ _____
b) Amount of outstanding interest on policy loan: $ ____
c) Current interest rate: _____
9) Has policy lapsed? ☐ no ☐ yes
a) If yes, when did policy lapse? ____/____/____
If policy has lapsed, is coverage continued under nonforfeiture option? ☐ no ☐ yes
If yes, indicate which option, amount of coverage, duration, etc.:_____
10) Is policy in force? ☐ no ☐ yes
a) If yes, has policy ever been reinstated? ☐ no ☐ yes
If yes, date of reinstatement: ____/____/____
11) Amount of contract/scheduled premiums: $ _____
12) Current premium mode: *(Monthly, Semiannually, etc.)*
d) When is next premium due?__/__/__ *(Month/Day/Year)*
13) Does the policy include a Disability Premium Waiver provision/rider? ☐ no ☐ yes
a) If yes, are premiums currently being waived?
☐ no ☐ yes
b) If yes, since when? ____/____/____
c) How often is continued eligibility reviewed? ____
d) When is next review? ____/____/____

14) Can payment of all or part of the death benefit be accelerated under this policy? ☐ no ☐ yes
a) If yes, by what method is the benefit calculated, the lien method or the discount method? _____
b) If lien method, what is the interest rate? _____
c) Can any remaining death benefit be assigned?
☐ no ☐ yes
15) Has a claim for Accelerated Death Benefit been submitted? ☐ no ☐ yes
a) If yes, was payment made under this provision?
☐ no ☐ yes
Amount paid: _____ Date paid: _____
16) Do current records show any assignments of record? ☐ no ☐ yes
17) Do current records show any outstanding liens or encumbrances of record? ☐ no ☐ yes
18) Please identify current primary beneficiaries: _____
e) Are they named irrevocably, or is owner otherwise limited in designation of new beneficiaries? ☐ no ☐ yes
19) Have any riders been added to this policy after issue? ☐ no ☐ yes
If yes, please identify: _____
20) If an ownership or beneficiary change or assignment were to be made on this policy, to whom would the completed forms be sent?
Name: _____ Title: _____
Company Name: _____ Department: _____
Address (No P.O. Box, please): _____
City: _____ ST: _____ ZIP: _____
Telephone Number: _____ Fax Number: _____
The answers provided reflect information contained in the company's records as of: _____ *(date)*
Signature: _____ Name (Printed): _____
Title: _____
Company: _____
Direct Telephone Number: _____
Direct Fax Number: _____

(b) The form for standardized viatical settlement verification of coverage for group policies is as follows:

VERIFICATION OF GROUP LIFE INSURANCE BENEFITS

Section One:

(To be Completed by the Viatical Settlement Provider, Broker, or Agent)

Insurance Company	Name of Employee/Member
Employer/Policyholder Name	Insured's Date of Birth
Policy Number	Insured's Social Security Number
Certificate Number	Employee/Membership Number

Please provide the information requested in Section Two or Section Three, as appropriate, with regard to the individual and coverage described, in accordance with the attached authorization.

In addition, please provide the forms checked below which are available from your company to complete a viatical settlement transaction:

☐ Absolute Assignment

☐ Change of Beneficiary (irrevocable if applicable)
☐ Disability Waiver of premium claim or
☐ Disability Waiver of premium award letter

Date

Signature of a representative of Viatical Settlement Provider, Broker, or Agent

Full name and address of Viatical Settlement Provider, Broker, or Agent

Section Two:
(To be Completed by the Employer/Group Policyholder)
1) BASIC COVERAGE
a) Is the plan self-insured or is coverage provided under a group policy issued by a life insurance company? _____
If by a group policy, please provide the name of the insurance company for BASIC life insurance coverage: _____

b) Effective date of BASIC life insurance coverage: _____
c) Face amount of BASIC life insurance: _____
d) Does BASIC life insurance coverage plan have contestable provisions? ☐ no ☐ yes
e) Is BASIC life insurance coverage subject to a suicide provision? ☐ no ☐ yes
f) Monthly premium paid by employer/group policyholder for BASIC life insurance coverage: $_____
g) Monthly premium paid by employee/insured for BASIC life insurance coverage: $_____
h) Is BASIC life insurance coverage ☐ Term ☐ Universal Life?
I) If Universal Life, please indicate cash value, if any: _____
Is this amount payable in addition to the face amount? ☐ no ☐ yes
i) Is coverage in force? ☐ no ☐ yes
j) When is next premium due? _____
k) Has employee's coverage under this plan ever been reinstated? ☐ no ☐ yes
I) If yes, date of reinstatement: _____
2) SUPPLEMENTAL (OPTIONAL) COVERAGE
a) Insurance Company for SUPPLEMENTAL life insurance coverage: _____
b) Effective date of SUPPLEMENTAL life insurance coverage: _____
c) Face amount of SUPPLEMENTAL life insurance: _____
d) Does SUPPLEMENTAL life insurance coverage plan have contestable provisions? ☐ no ☐ yes
e) Is SUPPLEMENTAL life insurance coverage subject to a suicide provision? ☐ no ☐ yes
f) Monthly premium paid by employer/group policyholder for SUPPLEMENTAL life insurance: $_____
g) Monthly premium paid by employee/insured for SUPPLEMENTAL life insurance: $_____
h) Is SUPPLEMENTAL life insurance coverage ☐ Term ☐ Universal Life?
I) If Universal Life, please indicate cash value, if any: _____
Is this amount payable in addition to the face amount? ☐ no ☐ yes
i) Is coverage in force? ☐ no ☐ yes
j) When is next premium due? _____
I) Has employee's coverage under this policy ever been reinstated? ☐ no ☐ yes
k) If yes, date of reinstatement: _____
3) DISABILITY WAIVER OF PREMIUM
a) Does plan provide for waiver of premium in the event of employee/insured's disability?
BASIC: ☐ no ☐ yes What is the waiting period? _____
SUPPLEMENTAL: ☐ no ☐ yes What is the waiting period? _____
b) Are premiums currently being waived under disability premium waiver?

BASIC: ☐ no ☐ yes
SUPPLEMENTAL: ☐ no ☐ yes

c) Who pays premiums under disability premium waiver?
BASIC: ☐ Insurance carrier ☐ Employer
SUPPLEMENTAL: ☐ Insurance carrier ☐ Employer

d) What was the date of approval? _____

e) Next review date? _____

f) If the insured is no longer eligible for waiver, what amount of coverage can be converted to an individual policy? $____

I) Will a new suicide/contestability clause be in effect for the converted policy? ☐ no ☐ yes

II) Will assignee be notified if insured is no longer eligible for waiver? ☐ no ☐ yes

4) BENEFICIARIES, ASSIGNMENTS, AND LIMITATIONS

a) Who are the primary beneficiaries of the coverage(s)?
BASIC: _____
SUPPLEMENTAL: _____

b) Is any beneficiary under this policy designated irrevocably, or is insured otherwise limited in designation of new beneficiaries? ☐ no ☐ yes

c) Can this coverage be assigned?
BASIC: ☐ no ☐ yes
If yes, to a corporation? ☐ no ☐ yes
To someone not related to insured? ☐ no ☐ yes
SUPPLEMENTAL: ☐ no ☐ yes
If yes, to a corporation? ☐ no ☐ yes
To someone not related to insured? ☐ no ☐ yes

d) Do records show any assignments of record?
☐ no ☐ yes

e) Do records show any outstanding liens or encumbrances of record? ☐ no ☐ yes

f) Will an Assignee be notified if the master policy is canceled? ☐ no ☐ yes

g) Can Assignee convert the coverage without the permission of insured? ☐ no ☐ yes

5) ACCELERATED DEATH BENEFITS

a) Is there an Accelerated Death Benefit available under the coverage?
BASIC: ☐ no ☐ yes
SUPPLEMENTAL: ☐ no ☐ yes

b) Has request for Accelerated Death Benefit been made? ☐ no ☐ yes

c) Has payment been made to insured under this provision? ☐ no ☐ yes
I) Amount paid: _____ Date paid: _____
II) Is this amount a lien against death proceeds?
☐ no ☐ yes
Interest rate_____
III) Can the remaining death benefit be assigned?
☐ no ☐ yes

6) MISCELLANEOUS

a) Is coverage portable?
BASIC: ☐ no ☐ yes
SUPPLEMENTAL: ☐ no ☐ yes

b) If insured is no longer eligible for coverage under the group, will Assignee be notified? ☐ no ☐ yes

c) If master policy discontinues, what amount can be converted to an individual policy?_____

d) Is this plan administered by a third party? ☐ no ☐ yes

If yes, please provide the name, address, and telephone number of administrator:

Name: _____ Title: _____
Company Name: _____ Department: _____
Street Address (No P.O. Box, please): _____
City: _____ State: _____ Zip: _____
Telephone Number: _____ Fax: _____
If a change of beneficiary form or assignment were to be made for this coverage, to whom should the completed forms be sent?
Name: _____ Title: _____
Company Name: _____ Department: _____
Street Address (No P.O. Box, please): _____
City: _____ State: _____ Zip: _____
Telephone Number: _____ Fax: _____
The answers provided reflect information in our files as of____ *(date)*.
Signature: _____ Name: _____
Date: _____ Title: _____
Company: _____
Direct Telephone Number: _____
Direct Fax Number: _____
Information not provided by the employer may be obtained from the insurance company if different from administrator identified above:
Name: _____ Title: _____
Company Name: _____ Department: _____
Address (No P.O. Box, please): _____
City: _____ State: _____ Zip: _____
Telephone Number: _____ Fax: _____
Section Three:
The insurance company or the third party administrator named above is requested to complete the information not provided by the employer in Section Two, above, Items number: _____.
The answers provided to the identified questions reflect information in the files of the insurance company as of ____ *(date)*.
Signature: _____ Name: _____
Date: _____ Title: _____
Company: _____
Telephone Number: _____
Fax Number: _____
(Department of Insurance; 760 IAC 1-61-12; filed Oct 20, 1999, 10:23 a.m.: 23 IR 584)

Rule 62. Life Insurance Illustrations

760 IAC 1-62-1 Applicability and scope

Authority: IC 27-1-3-7
Affected: IC 27-1-12-25; IC 27-4-1-4

Sec. 1. This rule applies to all group and individual life insurance policies and certificates, except any of the following:
(1) Variable life insurance.
(2) Individual and group annuity contracts.
(3) Credit life insurance.
(4) Life insurance policies with no illustrated death benefits on any individual exceeding ten thousand dollars ($10,000).

(Department of Insurance; 760 IAC 1-62-1; filed Sep 27, 1999, 9:00 a.m.: 23 IR 335, eff Jan 1, 2000)

760 IAC 1-62-2 Definitions

Authority: IC 27-1-3-7
Affected: IC 27-1-12-25; IC 27-4-1-4

Sec. 2. The following definitions apply throughout this rule:

(1) "Actuarial standards board" means the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

(2) "Commissioner" means the commissioner of the Indiana department of insurance.

(3) "Contract premium" means the gross premium that is required to be paid under a fixed premium policy, including the premium for a rider for which benefits are shown in the illustration.

(4) "Currently payable scale" means a scale of nonguaranteed elements in effect for a policy form as of the preparation date of the illustration or declared to become effective within the next ninety-five (95) days.

(5) "Disciplined current scale" means a scale of nonguaranteed elements constituting a limit on illustrations currently being illustrated by an insurer that is reasonably based on actual recent historical experience, as certified annually by an illustration actuary designated by the insurer. Further guidance in determining the disciplined current scale as contained in standards established by the actuarial standards board may be relied upon if the standards:

(A) are consistent with all provisions of this rule;

(B) limit a disciplined current scale to reflect only actions that have already been taken or events that have already occurred;

(C) do not permit a disciplined current scale to include any projected trends of improvements in experience or any assumed improvements in experience beyond the illustration date; and

(D) do not permit assumed expenses to be less than minimum assumed expenses.

(6) "Generic name" means a short title descriptive of the policy being illustrated, such as "whole life", "term life", or "flexible premium adjustable life".

(7) "Guaranteed elements" means the premiums, benefits, values, credits, or charges under a policy of life insurance that are guaranteed and determined at issue.

(8) "Illustrated scale" means a scale of nonguaranteed elements currently being illustrated that is not more favorable to the policy owner than the lesser of:

(A) the disciplined current scale; or

(B) the currently payable scale.

(9) "Illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years and that is one (1) of the following three (3) types:

(A) "Basic illustration" means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and nonguaranteed elements.

(B) "Supplemental illustration" means an illustration furnished in addition to a basic illustration that meets the applicable requirements of this rule, and that may be presented in a format differing from the basic illustration, but may only depict a scale of nonguaranteed elements that is permitted in a basic illustration.

(C) "In force illustration" means an illustration furnished at any time after the policy that it depicts has been in force for one (1) year or more.

(10) "Illustration actuary" means an actuary meeting the requirements of section 9 of this rule who certifies to illustrations based on the standard of practice promulgated by the Actuarial Standards Board.

(11) "Lapse-supported illustration" means an illustration of a policy form failing the test of self-supporting as defined in subdivision (17), under a modified persistency rate assumption using persistency rates underlying the disciplined current scale for the first five (5) years and one hundred percent (100%) policy persistency thereafter.

(12) "Minimum assumed expenses" means the minimum expenses that may be used in the calculation of the disciplined current scale for a policy form. The insurer may choose to designate each year the method of determining assumed expenses for all policy forms from the following:

(A) Fully allocated expenses.

(B) Marginal expenses.

(C) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the commissioner.

Marginal expenses may be used only if greater than a generally recognized expense table. If no generally recognized expense table is approved, fully allocated expenses must be used.

(13) "Nonguaranteed elements" means the premiums, benefits, values, credits, or charges under a policy of life insurance that are not guaranteed or not determined at issue.

(14) "Nonterm group life" means a group policy or individual policies of life insurance issued to members of an employer group or other permitted group where:

(A) every plan of coverage was selected by the employer or other group representative;

(B) some portion of the premium is paid by the group or through payroll deduction; and

(C) group underwriting or simplified underwriting is used.

(15) "Policy owner" means the owner named in the policy or the certificate holder in the case of a group policy.

(16) "Premium outlay" means the amount of premium assumed to be paid by the policy owner or other premium payer out-of-pocket.

(17) "Self-supporting illustration" means an illustration of a policy form for which it can be demonstrated that, when using experience assumptions underlying the disciplined current scale, for all illustrated points in time on or after the fifteenth policy anniversary or the twentieth policy anniversary for second-or-later-to-die policies (or upon policy expiration if sooner), the accumulated value of all policy cash flows equals or exceeds the total policy owner value available. For this purpose, policy owner value will include cash surrender values and any other illustrated benefit amounts available at the policy owner's election.

(Department of Insurance; 760 IAC 1-62-2; filed Sep 27, 1999, 9:00 a.m.: 23 IR 336, eff Jan 1, 2000)

760 IAC 1-62-3 Policies to be illustrated

Authority: IC 27-1-3-7
Affected: IC 27-1-12-25; IC 27-4-1-4

Sec. 3. (a) Each insurer marketing policies to which this rule is applicable shall notify the commissioner whether a policy form is to be marketed with or without an illustration. For all policy forms being actively marketed on the effective date of this rule, the insurer shall identify in writing those forms and whether or not an illustration will be used with them. For policy forms filed after the effective date of this rule, the identification shall be made at the time of filing. Any previous identification may be changed by notice to the commissioner.

(b) If the insurer identifies a policy form as one to be marketed without an illustration, any use of an illustration for any policy using that form prior to the first policy anniversary is prohibited.

(c) If a policy form is identified by the insurer as one to be marketed with an illustration, a basic illustration prepared and delivered in accordance with this rule is required, except that a basic illustration need not be provided to individual members of a group or to individuals insured under multiple lives coverage issued to a single applicant unless the coverage is marketed to these individuals. The illustration furnished an applicant for a group life insurance policy or policies issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

(d) Potential enrollees of nonterm group life subject to this rule shall be furnished a quotation with the enrollment materials. The quotation shall show potential policy values for sample ages and policy years on a guaranteed and nonguaranteed basis appropriate to the group and the coverage. This quotation shall not be considered an illustration for purposes of this rule, but all information provided shall be consistent with the illustrated scale. A basic illustration shall be provided at delivery of the certificate to enrollees for nonterm group life who enroll for more than the minimum premium necessary to provide pure death benefit protection. In addition, the insurer shall make a basic illustration available to any nonterm group life enrollee who requests it.
(Department of Insurance; 760 IAC 1-62-3; filed Sep 27, 1999, 9:00 a.m.: 23 IR 337, eff Jan 1, 2000)

760 IAC 1-62-4 General rules and prohibitions

Authority: IC 27-1-3-7
Affected: IC 27-1-12-25; IC 27-4-1-4

Sec. 4. (a) An illustration used in the sale of a life insurance policy shall satisfy the applicable requirements of this rule, be clearly labeled "life insurance illustration", and contain the following basic information:

(1) Name of insurer.

(2) Name and business address of producer or insurer's authorized representative, if any.

(3) Name, age, and sex of proposed insured, except where a composite illustration is permitted under this rule.

(4) Underwriting or rating classification upon which the illustration is based.

(5) Generic name of policy, the company product name, if different, and form number.

(6) Initial death benefit.

(7) Dividend option election or application of nonguaranteed elements, if applicable.

(b) When using an illustration in the sale of a life insurance policy, an insurer or its producers or other authorized representatives shall not do any of the following:

(1) Represent the policy as anything other than a life insurance policy.

(2) Use or describe nonguaranteed elements in a manner that is misleading or has the capacity or tendency to mislead.

(3) State or imply that the payment or amount of nonguaranteed elements is guaranteed.

(4) Use an illustration that does not comply with the requirements of this rule.

(5) Use an illustration that at any policy duration depicts policy performance more favorable to the policy owner than that produced by the illustrated scale of the insurer whose policy is being illustrated.

(6) Provide an applicant with an incomplete illustration.

(7) Represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits unless that is the fact.

(8) Use the term "vanish" or "vanishing premium" or a similar term that implies the policy becomes paid up to describe a plan for using nonguaranteed elements to pay a portion of future premiums.

(9) Except for policies that can never develop nonforfeiture values, use an illustration that is lapse-supported.

(10) Use an illustration that is not self-supporting.

(c) If an interest rate used to determine the illustrated nonguaranteed elements is shown, it shall not be greater than the earned interest rate underlying the disciplined current scale. *(Department of Insurance; 760 IAC 1-62-4; filed Sep 27, 1999, 9:00 a.m.: 23 IR 337, eff Jan 1, 2000)*

760 IAC 1-62-5 Basic illustrations

Authority: IC 27-1-3-7
Affected: IC 27-1-12-25; IC 27-4-1-4

Sec. 5. (a) A basic illustration shall conform with the following requirements:

(1) The illustration shall be labeled with the date on which it was prepared.

(2) Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the illustration, for example, the fourth page of a seven (7) page illustration shall be labeled "page 4 of 7 pages".

(3) The assumed dates of payment receipt and benefit pay-out within a policy year shall be clearly identified.

(4) If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the policy is assumed to have been in force.

(5) The assumed payments on which the illustrated benefits and values are based shall be identified as premium outlay or contract premium as applicable. For policies that do not require a specific contract premium, the illustrated payments shall be identified as premium outlay.

(6) Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium shall be shown and clearly labeled guaranteed.

(7) If the illustration shows any nonguaranteed elements, they cannot be based on a scale more favorable to the policy owner than the insurer's illustrated scale at any duration. These elements shall be clearly labeled nonguaranteed.

(8) The guaranteed elements, if any, shall be shown before corresponding nonguaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the nonguaranteed elements, for example, "see page one for guaranteed elements".
(9) The account or accumulation value of a policy, if shown, shall be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender.
(10) The value available upon surrender shall be identified by the name this value is given in the policy being illustrated and shall be the amount available to the policy owner in a lump sum after deduction of surrender charges, policy loans, and policy loan interest as applicable.
(11) Illustrations may show policy benefits and values in graphic or chart form in addition to the tabular form.
(12) Any illustration of nonguaranteed elements shall be accompanied by a statement indicating the following:
(A) The benefits and values are not guaranteed.
(B) The assumptions on which they are based are subject to change by the insurer.
(C) Actual results may be more or less favorable.
(13) If the illustration shows that the premium payer may have the option to allow policy charges to be paid using nonguaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on actual results, the premium payer may need to continue or resume premium outlays. Similar disclosure shall be made for premium outlay of lesser amounts or shorter durations than the contract premium. If a contract premium is due, the premium outlay display shall not be left blank or show zero (0) unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid up.
(14) If the applicant plans to use dividends or policy values, guaranteed or nonguaranteed, to pay all or a portion of the contract premium or policy charges, or for any other purpose, the illustration may reflect those plans and the impact on future policy benefits and values.
(b) The narrative summary of a basic illustration shall include the following:
(1) A brief description of the policy being illustrated, including a statement that it is a life insurance policy.
(2) A brief description of the premium outlay or contract premium, as applicable, for the policy. For a policy that does not require payment of a specific contract premium, the illustration shall show the premium outlay that must be paid to guarantee coverage for the term of the contract, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code.
(3) A brief description of any policy features, riders, or options, guaranteed or nonguaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the policy.
(4) Identification and a brief definition of column headings and key terms used in the illustration.
(5) A statement containing, in substance, the following: "This illustration assumes that the currently illustrated nonguaranteed elements will continue unchanged for all years shown. This is not likely to occur, and actual results may be more or less favorable than those shown.".
(c) Numeric summary information shall include the following:
(1) Following the narrative summary, a basic illustration shall include a numeric summary of the death benefits and values and the premium outlay and contract premium as applicable. For a policy that provides for a contract premium, the guaranteed death benefits and values shall be based on the contract premium. This summary shall be shown for at least policy years five (5), ten (10), and twenty (20) and at age seventy (70), if applicable, on the three (3) bases as follows:
(A) Policy guarantees.
(B) Insurer's illustrated scale.
(C) Insurer's illustrated scale used, but with the nonguaranteed elements reduced as follows:
(i) Dividends at fifty percent (50%) of the dividends contained in the illustrated scale used.
(ii) Nonguaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.
(iii) All nonguaranteed charges, including, but not limited to, term insurance charges, mortality, and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.
For multiple life policies the summary shall show policy years five (5), ten (10), twenty (20), and thirty (30).
(2) In addition, if coverage would cease prior to policy maturity or age one hundred (100), the year in which coverage ceases shall be identified for each of the three (3) bases.

(d) Statements substantially similar to the following shall be included on the same page as the numeric summary and signed by the applicant, or the policy owner in the case of an illustration provided at time of delivery, as required in this rule:

(1) A statement to be signed and dated by the applicant or policy owner reading, "I have received a copy of this illustration and understand that any nonguaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed.".

(2) A statement to be signed and dated by the insurance producer or other authorized representative of the insurer reading, "I certify that this illustration has been presented to the applicant and that I have explained that any nonguaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration.".

(e) Requirements for tabular detail are as follows:

(1) A basic illustration shall include the following for at least each policy year from one (1) to ten (10) and for every fifth policy year thereafter ending at age one hundred (100), policy maturity or final expiration, and, except for term insurance beyond the twentieth year, for any year in which the premium outlay and contract premium, if applicable, is to change:

(A) The premium outlay and mode the applicant plans to pay and the contract premium as applicable.

(B) The corresponding guaranteed death benefit as provided in the policy.

(C) The corresponding guaranteed value available upon surrender as provided in the policy.

(2) For a policy that provides for a contract premium, the guaranteed death benefit and value available upon surrender shall correspond to the contract premium.

(3) Nonguaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any nonguaranteed elements are shown, they must be shown at the same duration as the corresponding guaranteed elements, if any. If no guaranteed benefit or value is available at any duration for which a nonguaranteed benefit or value is shown, a zero (0) shall be displayed in the guaranteed column.

(Department of Insurance; 760 IAC 1-62-5; filed Sep 27, 1999, 9:00 a.m.: 23 IR 338, eff Jan 1, 2000)

760 IAC 1-62-6 Supplemental illustrations

Authority: IC 27-1-3-7
Affected: IC 27-1-12-25; IC 27-4-1-4

Sec. 6. (a) A supplemental illustration may be provided so long as the following requirements are met:

(1) It is appended to, accompanied by, or preceded by a basic illustration that complies with this rule.

(2) The nonguaranteed elements shown are not more favorable to the policy owner than the corresponding elements based on the scale used in the basic illustration.

(3) It contains the same statement required of a basic illustration that nonguaranteed elements are not guaranteed.

(4) For a policy that has a contract premium, the contract premium underlying the supplemental illustration is equal to the contract premium shown in the basic illustration. For policies that do not require a contract premium, the premium outlay underlying the supplemental illustration shall be equal to the premium outlay shown in the basic illustration.

(b) The supplemental illustration shall include a notice referring to the basic illustration for guaranteed elements and other important information. *(Department of Insurance; 760 IAC 1-62-6; filed Sep 27, 1999, 9:00 a.m.: 23 IR 339, eff Jan 1, 2000)*

760 IAC 1-62-7 Delivery of illustration and record retention

Authority: IC 27-1-3-7
Affected: IC 27-1-12-25; IC 27-4-1-4

Sec. 7. (a) If a basic illustration is used by an insurance producer or other authorized representative of the insurer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of that illustration, signed in accordance with this rule, shall be submitted to the insurer at the time of policy application. A copy also shall be provided to the applicant. If the policy is issued other than as applied for, a revised basic illustration conforming to the policy as issued shall be sent with the policy. The revised illustration shall:

(1) conform to the requirements of this rule;

(2) be labeled "Revised Illustration"; and

(3) be signed and dated by the applicant or policy owner and producer or other authorized representative of the insurer; no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

(b) If no illustration is used by an insurance producer or other authorized representative in the sale of a life insurance policy, or if the policy is applied for other than as illustrated, the producer or representative shall certify to that effect in writing on a form provided by the insurer. On the same form, the applicant shall acknowledge that no illustration conforming to the policy applied for was provided and shall further acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. This form shall be submitted to the insurer at the time of policy application. If the policy is issued, a basic illustration conforming to the policy as issued shall be sent with the policy and signed no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

(c) If the basic illustration or revised illustration is sent to the applicant or policy owner by mail from the insurer, it shall include instructions for the applicant or policy owner to sign the duplicate copy of the numeric summary page of the illustration for the policy issued and return the signed copy to the insurer. The insurer's obligation under this subsection shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the numeric summary page. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed, postage prepaid envelope with instructions for the return of the signed numeric summary page.

(d) A copy of the basic illustration and a revised basic illustration, if any, signed, as applicable, along with any certification that either no illustration was used or that the policy was applied for other than as illustrated, shall be retained by the insurer until three (3) years after the policy is no longer in force. A copy need not be retained if no policy is issued. *(Department of Insurance; 760 IAC 1-62-7; filed Sep 27, 1999, 9:00 a.m.: 23 IR 339, eff Jan 1, 2000)*

760 IAC 1-62-8 Annual report; notice to policy owners

Authority: IC 27-1-3-7
Affected: IC 27-1-12-25; IC 27-4-1-4

Sec. 8. (a) In the case of a policy designated as one for which illustrations will be used, the insurer shall provide each policy owner with an annual report on the status of the policy that shall contain at least the following information:

(1) For universal life policies, the report shall include the following:

(A) The beginning and end date of the current report period.

(B) The policy value at the end of the previous report period and at the end of the current report period.

(C) The total amounts that have been credited or debited to the policy value during the current report period, identifying each by type, for example, the following:

(i) Interest.

(ii) Mortality.

(iii) Expense.

(iv) Riders.

(D) The current death benefit at the end of the current report period on each life covered by the policy.

(E) The net cash surrender value of the policy as of the end of the current report period.

(F) The amount of outstanding loans, if any, as of the end of the current report period.

(G) For fixed premium policies, if, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report.

(H) For flexible premium policies, if, assuming guaranteed interest, mortality, and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to this effect shall be included in the report.

(2) For all other policies, where applicable:

(A) current death benefit;

(B) annual contract premium;

(C) current cash surrender value;

(D) current dividend;

(E) application of current dividend; and

(F) amount of outstanding loan.

(3) Insurers writing life insurance policies that do not build nonforfeiture values shall only be required to provide an annual report with respect to these policies for those years when a change has been made to nonguaranteed policy elements by the insurer.

(b) If the annual report does not include an in force illustration, it shall contain a notice, displayed prominently stating, "IMPORTANT POLICY OWNER NOTICE: You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling [insurer's phone number], writing to [insurer's name] at [insurer's address], or contacting your agent. If you do not receive a current illustration of your policy within thirty (30) days from your request, you should contact your state insurance department.". The insurer may vary the sequential order of the methods for obtaining an in force illustration.

(c) Upon the request of the policy owner, the insurer shall furnish an in force illustration of current and future benefits and values based on the insurer's present illustrated scale. This illustration shall comply with the requirements of sections 4(a), 4(b), 5(a), and 5(e) of this rule. No signature or other acknowledgment of receipt of this illustration shall be required.

(d) If an adverse change in nonguaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report shall contain a notice of that fact and the nature of the change prominently displayed. *(Department of Insurance; 760 IAC 1-62-8; filed Sep 27, 1999, 9:00 a.m.: 23 IR 340, eff Jan 1, 2000)*

760 IAC 1-62-9 Annual certifications

Authority: IC 27-1-3-7
Affected: IC 27-1-12-25; IC 27-4-1-4

Sec. 9. (a) The board of directors of each insurer shall appoint one (1) or more illustration actuaries.

(b) The illustration actuary shall certify that:

(1) the disciplined current scale used in illustrations is in conformity with the Actuarial Standard of Practice for Compliance with the National Association of Insurance Commissioners Model Regulation on Life Insurance Illustrations promulgated by the Actuarial Standards Board; and

(2) the illustrated scales used in insurer-authorized illustrations meet the requirements of this rule.

(c) Requirements for an illustration actuary shall be as follows:

(1) Be a member in good standing of the American Academy of Actuaries.

(2) Be familiar with the standard of practice regarding life insurance policy illustrations.

(3) Not have been found by the commissioner, following appropriate notice and hearing, to have:

(A) violated any provision of, or any obligation imposed by, the insurance law or other law in the course of his or her dealings as an illustration actuary;

(B) been found guilty of fraudulent or dishonest practices;

(C) demonstrated his or her incompetence, lack of cooperation, or untrustworthiness to act as an illustration actuary; or

(D) resigned or been removed as an illustration actuary within the past five (5) years as a result of acts or omissions indicated in any adverse report on examination or as a result of a failure to adhere to generally acceptable actuarial standards.

(4) Not fail to notify the commissioner of any action taken by a commissioner of another state similar to that under subdivision (3).

(5) Disclose in the annual certification whether, since the last certification, a currently payable scale applicable for business issued within the previous five (5) years and within the scope of the certification has been reduced for reasons other than changes in the experience factors underlying the disciplined current scale. If nonguaranteed elements illustrated for new policies are not consistent with those illustrated for similar in force policies, disclosure shall be made in the annual certification. If nonguaranteed elements illustrated for both new and in force policies are not consistent with the nonguaranteed elements actually being paid, charged, or credited to the same or similar forms, disclosure shall be made in the annual certification.

(6) Disclose in the annual certification the method used to allocate overhead expenses for all illustrations, including:

(A) fully allocated expenses;

(B) marginal expenses; or

(C) a generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the commissioner.

(d) The illustration actuary shall file a certification with the board of directors of the insurer and with the commissioner:

(1) annually for all policy forms for which illustrations are used; and

(2) before a new policy form is illustrated.

If an error in a previous certification is discovered, the illustration actuary shall notify the board of directors of the insurer and the commissioner promptly.

(e) If an illustration actuary is unable to certify the scale for any policy form illustration the insurer intends to use, the actuary shall notify the board of directors of the insurer and the commissioner promptly of his or her inability to certify.

(f) A responsible officer of the insurer, other than the illustration actuary, shall certify annually that the:

(1) illustration formats meet the requirements of this rule, and the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary; and

(2) company has provided its agents with information about the expense allocation method used by the company in its illustrations and made disclosures as required in subsection (c)(6).

(g) The annual certifications shall be provided to the commissioner each year by a date determined by the insurer.

(h) If an insurer changes the illustration actuary responsible for all or a portion of the company's policy forms, the insurer shall notify the commissioner of that fact promptly and disclose the reason for the change. *(Department of Insurance; 760 IAC 1-62-9; filed Sep 27, 1999, 9:00 a.m.: 23 IR 341, eff Jan 1, 2000)*

760 IAC 1-62-10 Penalties

Authority: IC 27-1-3-7
Affected: IC 27-1-12-25; IC 27-4-1-4

Sec. 10. In addition to any other penalties provided by the laws of this state, an insurer or producer that violates a requirement of this rule shall be guilty of an unfair and deceptive act or practice. *(Department of Insurance; 760 IAC 1-62-10; filed Sep 27, 1999, 9:00 a.m.: 23 IR 342, eff Jan 1, 2000)*

760 IAC 1-62-11 Separability

Authority: IC 27-1-3-7
Affected: IC 27-1-12-25; IC 27-4-1-4

Sec. 11. If any provision of this rule or its application to any person or circumstance is for any reason held to be invalid by any court of law, the remainder of the rule and its application to other persons or circumstances shall not be affected. *(Department of Insurance; 760 IAC 1-62-11; filed Sep 27, 1999, 9:00 a.m.: 23 IR 342, eff Jan 1, 2000)*

Rule 63. Health Maintenance Organization Comparison Sheets

760 IAC 1-63-1 Authority

Authority: P.L.69-1998, SEC.19
Affected: IC 27-13-40-1

Sec. 1. (a) Beginning January 1, 2000, each health maintenance organization shall complete and maintain a health maintenance organization comparison sheet for each policy or contract that covers or is marketed to an Indiana resident or the resident's employer.

(b) Each health maintenance organization shall modify its health maintenance organization comparison sheet whenever necessary to accurately reflect information about the health maintenance organization.

(c) The format for and elements of the health maintenance organization comparison sheet are set forth in section 2 of this rule. Health maintenance organizations shall report on Part C of the comparison sheet the same information reported to the National Committee for Quality Assurance (NCQA) for its Health Plan Employer Data and Information Set (HEDIS) measures. Information

reported shall be for Indiana only. A description of the HEDIS measures shall be displayed as a footnote to each quality measure reported on Part C of the comparison sheet.

(d) A health maintenance organization shall make available upon request to any person to whom a health maintenance organization comparison sheet has or will be delivered all information reported by the health maintenance organization to the NCQA for its HEDIS measures. *(Department of Insurance; 760 IAC 1-63-1; filed Jul 29, 1999, 11:02 a.m.: 22 IR 3933, eff Jan 1, 2000)*

760 IAC 1-63-2 HMO comparison sheet

Authority: P.L.69-1998, SEC.19
Affected: IC 27-13-40-1; IC 27-13-40-2

Sec. 2. The format for and elements of the health maintenance organization comparison sheet are as follows:

HMO NAME:_____

NAME OF PROVIDER NETWORK:_____

Information current as of: [date]

THE FOLLOWING INFORMATION IS A SUMMARY ONLY. PLEASE REVIEW YOUR CERTIFICATE OF COVERAGE FOR A COMPLETE DESCRIPTION OF BENEFITS, LIMITATIONS, AND EXCLUSIONS.

DESCRIPTION OF THE PLAN: [Provide a brief description of the process an enrollee must follow to access care. Explain the role of the primary care physician and restrictions regarding out-of-network benefits and coverage, if applicable.]

PART A: BENEFIT INFORMATION

Benefit	Description	Copayment or Other Charge	Additional Information
PHYSICIAN SERVICES (Indicate differences among primary care physician, specialists, and other where appropriate)			
Office visits			
Routine physicals			
Well baby and child care, including immunizations			
Mammograms			
Maternity (physician and hospital services)			
Surgery			
Other			
OUTPATIENT HOSPITAL SERVICES			
Surgery and related charges			
Physician services			
Emergency care: in area (___mile radius) out of area (___mile radius)			
Other			
INPATIENT HOSPITAL SERVICES			
Room and board (indicate any limitations regarding choice of hospital)			
Physician services			
Rehabilitative services (including speech, physical, and occupational therapy)			
Other			
PRESCRIPTION DRUGS			
Formulary brand			
Formulary nonbrand			
Nonformulary brand			

Nonformulary nonbrand (generic)			
Diabetic supplies			
LABORATORY AND X-RAY (diagnostic and routine)			
SKILLED NURSING FACILITY [insert description of what constitutes a "skilled nursing facility"]			
HOME HEALTH SERVICES			
DURABLE MEDICAL EQUIPMENT			
PROSTHETICS			
FAMILY PLANNING			
Voluntary sterilization: Male: Female:			
Contraceptive drugs and devices			
INFERTILITY DIAGNOSTIC TESTING			
FERTILITY COVERAGE			
MENTAL HEALTH			
Outpatient			
Inpatient			
SUBSTANCE ABUSE and CHEMICAL DEPENDENCY			
Outpatient			
Inpatient			
THERAPY			
Physical			
Speech			
Occupational			
VISION			
Eye exams			
Glasses or contacts			
Corrective surgery			
HEARING			
Testing			
Hearing aids			
DENTAL			
Preventative			
Orthodontia			
Emergency			
EXCLUSIONS			

PART B: SERVICE AREA

General description of service area:	
Indicate metropolitan areas served:	
Indicate nonmetropolitan areas served:	

PART C: QUALITY MEASURES

Additional quality measures, including measures of effectiveness of care and access/availability of care, are available by

calling [insert phone number] or writing [insert address].

Quality Measures	[Reporting HMO]
Percentage of primary care physicians who are board certified	
Provider turnover rate	
Disenrollment	
Years in business/total membership (Indiana and national)	
Satisfaction with the experience of care	
Accreditations achieved	

PART D: GRIEVANCE INFORMATION

A Grievance Procedures Report, which contains information about the number, type, and resolution of grievances filed with the HMO during the previous calendar year, is available upon request by calling [insert phone number] or writing [insert address]. *(Department of Insurance; 760 IAC 1-63-2; filed Jul 29, 1999, 11:02 a.m.: 22 IR 3933, eff Jan 1, 2000)*

Rule 64. Valuation of Life Insurance Policies

760 IAC 1-64-1 Scope

Authority: IC 27-1-12-10.5
Affected: IC 27-1-12-10; IC 27-1-12-10.1

Sec. 1. (a) Except as provided in subsection (c), this rule shall apply to all life insurance policies, with or without nonforfeiture values, issued on or after January 1, 2000.

(b) The method for calculating basic reserves defined in this rule will constitute the commissioner's reserve valuation method for policies to which this rule is applicable.

(c) This rule shall not apply to the following:

(1) Any individual life insurance policy issued in accordance with and as a result of the exercise of a reentry provision contained in a previously issued life insurance policy if:

(A) the previously issued policy was issued before the effective date of this rule;

(B) the previously issued policy has a face amount greater than or equal to the face amount of the new policy; and

(C) the reentry provision guarantees the premium rates of the new policy.

(2) Any individual life insurance policy issued in accordance with and pursuant to the exercise of a reentry provision contained in a new policy described in subdivision (1) or a derivation of such provision.

(3) Any universal life policy that meets the following requirements:

(A) Secondary guarantee period, if any, is five (5) years or less.

(B) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the 1980 CSO valuation tables as defined in section 2(b) of this rule and the applicable valuation interest rate.

(C) The initial surrender charge is not less than one hundred percent (100%) of the first year annualized specified premium for the secondary guarantee period.

(4) Any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(5) Any variable universal life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(6) A group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one (1) year.

(d) Calculation of the minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies), or both, shall be in accordance with the provisions of section 4 of this rule.

(e) Calculation of the minimum valuation standard for flexible premium and fixed premium universal life insurance policies that contain provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period shall be in accordance with the provisions of section 5 of this rule. *(Department of Insurance; 760 IAC 1-64-1; filed Dec 1, 1999, 3:20*

p.m.: 23 IR 796)

760 IAC 1-64-2 Definitions

Authority: IC 27-1-12-10.5
Affected: IC 27-1-12-10; IC 27-1-12-10.1

Sec. 2. (a) In addition to the definitions in IC 27-1-12-10, the definitions in this section apply throughout this rule.

(b) "1980 CSO valuation tables" means the commissioners' 1980 standard ordinary mortality table without ten-year selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law, and variations of the 1980 commissioners' standard ordinary mortality table approved by the NAIC, such as the smoker and nonsmoker versions approved in December 1983.

(c) "Basic reserves" means reserves calculated in accordance with IC 27-1-12-10(3).

(d) "Contract segmentation method" means the method of dividing the period from issue to mandatory expiration of a policy into successive segments, with the length of each segment being defined as the period from the end of the prior segment (from policy inception, for the first segment) to the end of the latest policy year as determined in this subsection. All calculations are made using the 1980 CSO valuation tables, as defined in subsection (b), (or any other valuation mortality table adopted by the NAIC after the effective date of this rule and promulgated by rule by the commissioner for this purpose), and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in section 3(b) of this rule. The length of a particular contract segment shall be set equal to the minimum of the value *t* for which G_t is greater than R_t (if G_t never exceeds R_t, the segment length is deemed to be the number of years from the beginning of the segment to the mandatory expiration date of the policy), where G_t and R_t are defined as follows:

$$G_t = \frac{GP_{x+k+t}}{GP_{x+k+t-1}}$$

Where:
- x = Original issue age.
- k = The number of years from the date of issue to the beginning of the segment.
- t = 1, 2,...; *t* is reset to 1 at the beginning of each segment.
- $GP_{x+k+t-1}$ = Guaranteed gross premium per thousand of face amount for year *t* of the segment, ignoring policy fees only if level for the premium paying period of the policy.

$$R_t = \frac{q_{x+k+t}}{q_{x+k+t-1}}$$

However, R_t may be increased or decreased by one percent (1%) in any policy year, at the company's option, but R_t shall not be less than one (1):

Where:
- x = Original issue age.
- k = The number of years from the date of issue to the beginning of the segment.
- t = 1, 2,...; *t* is reset to 1 at the beginning of each segment.
- $q_{x+k+t-1}$ = Valuation mortality rate for deficiency reserves in policy year k+t, but using the mortality of section 3(b)(2) of this rule if section 3(b)(3) of this rule is elected for deficiency reserves.

However, if GP_{x+k+t} is greater than zero (0) and $GP_{x+k+t-1}$ is equal to zero (0), G_t shall be deemed to be one thousand (1,000). If GP_{x+k+t} and $GP_{x+k+t-1}$ are both equal to zero (0), G_t shall be deemed to be zero (0).

(e) "Deficiency reserves" means the excess, if greater than zero (0), of minimum reserves calculated in accordance with IC 27-1-12-10(6) over basic reserves.

(f) "Guaranteed gross premiums" means the premiums under a policy of life insurance that are guaranteed and determined at issue.

(g) "Maximum valuation interest rates" means the interest rates defined in IC 27-1-12-10(2)(j)(A) (computation of minimum standard by calendar year of issue) that are to be used in determining the minimum standard for the valuation of life insurance policies.

(h) "NAIC" means National Association of Insurance Commissioners.

(i) "Scheduled gross premium" means the smallest illustrated gross premium at issue for other than universal life insurance

policies. For universal life insurance policies, the term means the smallest specified premium described in section 5(a)(3) of this rule if any, or else the minimum premium described in section 5(a)(4) of this rule.

(j) "Segmented reserves" means reserves, calculated using segments produced by the contract segmentation method, equal to the present value of all future guaranteed benefits less the present value of all future net premiums to the mandatory expiration of a policy, where the net premiums within each segment are a uniform percentage of the respective guaranteed gross premiums within the segment. The following requirements apply to each segment:

(1) The uniform percentage for each segment of segmented reserves is such that, at the beginning of the segment, the present value of the net premiums within the segment equals:

(A) the present value of the death benefits within the segment; plus

(B) the present value of any unusual guaranteed cash value as described in section 4(d) of this rule, occurring at the end of the segment; less

(C) any unusual guaranteed cash value occurring at the start of the segment; plus

(D) for the first segment only, the excess of item (i) over item (ii) as follows:

(i) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for in the first segment after the first policy year, divided by the present value, at the date of issue, of an annuity of one (1) per year payable on the first and each subsequent anniversary within the first segment on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one (1) year higher than the age at issue of the policy.

(ii) A net one-year term premium for the benefits provided for in the first policy year.

(2) The length of each segment is determined by the contract segmentation method as defined in subsection (d).

(3) The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the sum of the lengths of all segments of the policy.

(4) For both basic reserves and deficiency reserves computed by the segmented method, present values shall include future benefits and net premiums in the current segment and in all subsequent segments.

(k) "Tabular cost of insurance" means the net single premium at the beginning of a policy year for one-year term insurance in the amount of the guaranteed death benefit in that policy year.

(l) "Ten-year select factors" means the select factors adopted with the 1980 amendments to the NAIC Standard Valuation Law.

(m) "Unitary reserves" means the present value of all future guaranteed benefits less the present value of all future modified net premiums. The following conditions apply to the calculation of unitary reserves:

(1) Guaranteed benefits and modified net premiums are considered to the mandatory expiration of the policy.

(2) Modified net premiums are a uniform percentage of the respective guaranteed gross premiums, where the uniform percentage is such that, at issue, the present value of the net premiums equals the present value of all death benefits and pure endowments, plus the excess of clause (A) over clause (B) as follows:

(A) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one (1) per year payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one (1) year higher than the age at issue of the policy.

(B) A net one-year term premium for the benefits provided for in the first policy year.

The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the length from issue to the mandatory expiration of the policy.

(n) "Universal life insurance policy" means any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality or expense charges are made to the policy. *(Department of Insurance; 760 IAC 1-64-2; filed Dec 1, 1999, 3:20 p.m.: 23 IR 797)*

760 IAC 1-64-3 Basic reserves and premium deficiency reserves; general calculation

Authority: IC 27-1-12-10.5

Affected: IC 27-1-12-10; IC 27-1-12-10.1

Sec. 3. (a) At the election of the company for any one (1) or more specified plans of life insurance, the minimum mortality standard for basic reserves may be calculated using the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this rule and promulgated by rule by the commissioner of the department of insurance (commissioner) for this purpose). If select mortality factors are elected, they may be:

(1) the ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

(2) the select mortality factors set forth in section 6 of this rule; or

(3) any other table of select mortality factors adopted by the NAIC after the effective date of this rule and promulgated by rule by the commissioner for the purpose of calculating basic reserves.

(b) Deficiency reserves, if any, are calculated for each policy as the excess, if greater than zero (0), of the quantity A over the basic reserve. The quantity A is obtained by recalculating the basic reserve for the policy using guaranteed gross premiums instead of net premiums when the guaranteed gross premiums are less than the corresponding net premiums. At the election of the company for any one (1) or more specified plans of insurance, the quantity A and the corresponding net premiums used in the determination of quantity A may be based upon the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this rule and promulgated by rule by the commissioner). If select mortality factors are elected, they may be the following:

(1) The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law.

(2) The select mortality factors set forth in section 6 of this rule.

(3) For durations in the first segment, X percent of the select mortality factors set forth in section 6 of this rule, subject to the following:

(A) X may vary by:

(i) policy year;

(ii) policy form;

(iii) underwriting classification;

(iv) issue age; or

(v) any other policy factor expected to affect mortality experience.

(B) X shall not be less than twenty percent (20%).

(C) X shall not decrease in any successive policy years.

(D) X is such that, when using the valuation interest rate used for basic reserves, the actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X is greater than or equal to the actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date.

(E) X is such that the mortality rates resulting from the application of X are at least as great as the anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first five (5) years after the valuation date.

(F) The appointed actuary shall increase X at any valuation date where it is necessary to continue to meet all the requirements of this subdivision.

(G) The appointed actuary may decrease X at any valuation date as long as X does not decrease in any successive policy years and as long as it continues to meet all the requirements of this subdivision.

(H) The appointed actuary shall specifically take into account the adverse effect on expected mortality and lapsation of any anticipated or actual increase in gross premiums.

(I) If X is less than one hundred percent (100%) at any duration for any policy, the following requirements shall be met:

(i) The appointed actuary shall annually prepare an actuarial opinion and memorandum for the company in conformance with the requirements of 760 IAC 1-57-8.

(ii) The appointed actuary shall annually opine for all policies subject to this rule as to whether the mortality rates resulting from the application of X meet the requirements of this subdivision. This opinion shall be supported by an actuarial report, subject to appropriate Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries. The X factors shall reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience.

(4) Any other table of select mortality factors adopted by the NAIC after the effective date of this rule and promulgated by

rule by the commissioner for the purpose of calculating deficiency reserves.

(c) This subsection applies to both basic reserves and deficiency reserves. Any set of select mortality factors may be used only for the first segment. However, if the first segment is less than ten (10) years, the appropriate ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law may be used thereafter through the tenth policy year from the date of issue.

(d) In determining basic reserves or deficiency reserves, guaranteed gross premiums without policy fees may be used where the calculation involves the guaranteed gross premium but only if the policy fee is a level dollar amount after the first policy year. In determining deficiency reserves, policy fees may be included in guaranteed gross premiums, even if not included in the actual calculation of basic reserves.

(e) Reserves for policies that have changes to guaranteed gross premiums, guaranteed benefits, guaranteed charges, or guaranteed credits that are unilaterally made by the insurer after issue and that are effective for more than one (1) year after the date of the change shall be the greatest of the following:

(1) Reserves calculated ignoring the guarantee.

(2) Reserves assuming the guarantee was made at issue.

(3) Reserves assuming that the policy was issued on the date of the guarantee.

(f) The commissioner may require that the company document the extent of the adequacy of reserves for specified blocks, including, but not limited to, policies issued prior to the effective date of this rule. This documentation may include a demonstration of the extent to which aggregation with other nonspecified blocks of business is relied upon in the formation of the appointed actuary opinion pursuant to and consistent with the requirements of 760 IAC 1-57-8. *(Department of Insurance; 760 IAC 1-64-3; filed Dec 1, 1999, 3:20 p.m.: 23 IR 798)*

760 IAC 1-64-4 Calculation of minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies)

Authority: IC 27-1-12-10.5
Affected: IC 27-1-12-10; IC 27-1-12-10.1

Sec. 4. (a) Basic reserves shall be calculated as the greater of the segmented reserves and the unitary reserves. Both the segmented reserves and the unitary reserves for any policy shall use the same valuation mortality table and selection factors. At the option of the insurer, in calculating segmented reserves and net premiums, either of the adjustments described as follows may be made:

(1) Treat the unitary reserve, if greater than zero (0), applicable at the end of each segment as a pure endowment and subtract the unitary reserve, if greater than zero (0), applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

(2) Treat the guaranteed cash surrender value, if greater than zero (0), applicable at the end of each segment as a pure endowment, and subtract the guaranteed cash surrender value, if greater than zero (0), applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

(b) Requirements for deficiency reserves shall be as follows:

(1) The deficiency reserve at any duration shall be calculated:

(A) on a unitary basis if the corresponding basic reserve determined by subsection (a) is unitary;

(B) on a segmented basis if the corresponding basic reserve determined by subsection (a) is segmented; or

(C) on a segmented basis if the corresponding basic reserve determined by subsection (a) is equal to both the segmented reserve and the unitary reserve.

(2) This subsection applies to any policy for which the guaranteed gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the basic reserves, but using the minimum valuation standards of mortality specified in section 3(b) of this rule and rate of interest.

(3) Deficiency reserves, if any, shall be calculated for each policy as the excess if greater than zero (0), for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated in section 3(b) of this rule.

(4) For deficiency reserves determined on a segmented basis, the quantity A is determined using segment lengths equal to those determined for segmented basic reserves.

(c) Basic reserves may not be less than the tabular cost of insurance for the balance of the policy year if mean reserves are

used. Basic reserves may not be less than the tabular cost of insurance for the balance of the current modal period or to the paid-to-date, if later, but not beyond the next policy anniversary, if mid-terminal reserves are used. The tabular cost of insurance shall use the same valuation mortality table and interest rates as that used for the calculation of the segmented reserves. However, if select mortality factors are used, they shall be the ten-year select factors incorporated into the 1980 amendments of the NAIC Standard Valuation Law. In no case may total reserves (including basic reserves, deficiency reserves, and any reserves held for supplemental benefits that would expire upon contract termination) be less than the amount that the policy owner would receive (including the cash surrender value of the supplemental benefits, if any, referred to in this subsection), exclusive of any deduction for policy loans, upon termination of the policy.

(d) The following requirements apply to an unusual pattern of guaranteed cash surrender values:

(1) For any policy with an unusual pattern of guaranteed cash surrender values, the reserves actually held prior to the first unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the first unusual guaranteed cash surrender value as a pure endowment and treating the policy as an *n* year policy providing term insurance plus a pure endowment equal to the unusual cash surrender value, where *n* is the number of years from the date of issue to the date the unusual cash surrender value is scheduled.

(2) The reserves actually held subsequent to any unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the policy as an *n* year policy providing term insurance plus a pure endowment equal to the next unusual guaranteed cash surrender value, and treating any unusual guaranteed cash surrender value at the end of the prior segment as a net single premium, where:

(A) *n* is the number of years from the date of the last unusual guaranteed cash surrender value prior to the valuation date to the earlier of:

(i) the date of the next unusual guaranteed cash surrender value, if any, that is scheduled after the valuation date; or

(ii) the mandatory expiration date of the policy;

(B) the net premium for a given year during the *n* year period is equal to the product of the net to gross ratio and the respective gross premium; and

(C) the net to gross ratio is equal to:

(i) the present value, at the beginning of the *n* year period, of death benefits payable during the *n* year period plus the present value, at the beginning of the *n* year period, of the next unusual guaranteed cash surrender value, if any, minus the amount of the last unusual guaranteed cash surrender value, if any, scheduled at the beginning of the *n* year period; divided by

(ii) the present value, at the beginning of the *n* year period, of the scheduled gross premiums payable during the *n* year period.

(3) For purposes of this subsection, a policy is considered to have an unusual pattern of guaranteed cash surrender values if any future guaranteed cash surrender value exceeds the prior year's guaranteed cash surrender value by more than the sum of:

(A) One hundred ten percent (110%) of the scheduled gross premium for that year.

(B) One hundred ten percent (110%) of one (1) year's accrued interest on the sum of the prior year's guaranteed cash surrender value and the scheduled gross premium using the nonforfeiture interest rate used for calculating policy guaranteed cash surrender values.

(C) Five percent (5%) of the first policy year surrender charge, if any.

(e) At the option of the company, the following approach for reserves on yearly renewable term reinsurance may be used:

(1) Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

(2) Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in subsection (c).

(3) Deficiency reserves:

(A) for each policy year, calculate the excess, if greater than zero (0), of the valuation net premium over the respective maximum guaranteed gross premium; and

(B) shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with clause (A).

(4) For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO mortality

tables with or without ten-year select mortality factors, or any other table adopted after the effective date of this rule by the NAIC and promulgated by rule by the commissioner of the department of insurance (commissioner) for this purpose.

(5) A reinsurance agreement shall be considered yearly renewable term reinsurance for purposes of this subsection if only the mortality risk is reinsured.

(6) If the assuming company chooses the optional exemption, the ceding company's reinsurance reserve credit shall be limited to the amount of reserve held by the assuming company for the affected policies.

(f) At the option of the company, the following approach for reserves for attained-age-based yearly renewable term life insurance policies may be used:

(1) Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

(2) Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in subsection (c).

(3) Deficiency reserves:

(A) for each policy year, calculate the excess, if greater than zero (0), of the valuation net premium over the respective maximum guaranteed gross premium; and

(B) shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with clause (A).

(4) For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, or any other table adopted after the effective date of this rule by the NAIC and promulgated by rule by the commissioner for this purpose.

(5) A policy shall be considered an attained-age-based yearly renewable term life insurance policy for purposes of this subsection if:

(A) the premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are based upon the attained age of the insured such that the rate for any given policy at a given attained age of the insured is independent of the year the policy was issued; and

(B) the premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are the same as the premium rates for policies covering all insureds of the same sex, risk class, plan of insurance, and attained age.

(6) For policies that become attained-age-based yearly renewable term policies after an initial period of coverage, the approach of this subsection may be used after the initial period if:

(A) the initial period is constant for all insureds of the same sex, risk class, and plan of insurance, or the initial period runs to a common attained age for all insureds of the same sex, risk class, and plan of insurance; and

(B) after the initial period of coverage, the policy meets the conditions of subdivision (5).

(7) If this election is made, this approach shall be applied in determining reserves for all attained-age-based yearly renewable term life insurance policies issued on or after the effective date of this rule.

(g) Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met:

(1) The policy consists of a series of *n*-year periods, including the first period and all renewal periods, where *n* is the same for each period, except that for the final renewal period, *n* may be truncated or extended to reach the expiry age, provided that this final renewal period is less than ten (10) years and less than twice the size of the earlier *n*-year periods, and for each period, the premium rates on both the initial current premium scale and the guaranteed maximum premium scale are level.

(2) The guaranteed gross premiums in all *n*-year periods are not less than the corresponding net premiums based upon the 1980 CSO Table with or without the ten-year select mortality factors.

(3) There are no cash surrender values in any policy year.

(h) Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met, based upon the initial current premium scale at issue:

(1) The insured is twenty-four (24) years of age or younger.

(2) Until the insured reaches the end of the juvenile period, which shall occur at or before twenty-five (25) years of age, the gross premiums and death benefits are level, and there are no cash surrender values.

(3) After the end of the juvenile period, gross premiums are level for the remainder of the premium paying period, and death benefits are level for the remainder of the life of the policy.

(Department of Insurance; 760 IAC 1-64-4; filed Dec 1, 1999, 3:20 p.m.: 23 IR 800)

760 IAC 1-64-5 Calculation of minimum valuation standard for flexible premium and fixed premium universal life insurance policies that contain provisions resulting in the ability of a policy owner to keep a policy in force over a secondary guarantee period

Authority: IC 27-1-12-10.5
Affected: IC 27-1-12-10; IC 27-1-12-10.1

Sec. 5. (a) General provisions regarding secondary guarantees are as follows:

(1) Policies with a secondary guarantee include, but are not limited to, any of the following:

(A) A policy with a guarantee that the policy will remain in force at the original schedule of benefits, subject only to the payment of specified premiums.

(B) A policy in which the minimum premium at any duration is less than the corresponding one (1) year valuation premium, calculated using the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, or any other table adopted after the effective date of this rule by the NAIC and promulgated by rule by the commissioner of the department of insurance (commissioner) for this purpose.

(C) A policy with any combination of clauses (A) and (B).

(2) A secondary guarantee period is the period for which the policy is guaranteed to remain in force subject only to a secondary guarantee. When a policy contains more than one (1) secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees. Secondary guarantees that are unilaterally changed by the insurer after issue shall be considered to have been made at issue. Reserves described in subsections (b) and (c) shall be recalculated from issue to reflect these changes.

(3) As used in this section, "specified premiums" means the premiums specified in the policy (or imputable by the terms of the policy), the payment of which guarantees that the policy will remain in force at the original schedule of benefits, but which otherwise would be insufficient to keep the policy in force in the absence of the guarantee if maximum mortality and expense charges and minimum interest credits were made and any applicable surrender charges were assessed.

(4) For purposes of this section, the minimum premium for any policy year is the premium that, when paid into a policy with a zero (0) account value at the beginning of the policy year, produces a zero (0) account value at the end of the policy year. The minimum premium calculation shall use the policy cost factors (including mortality charges, loads, and expense charges) and the interest crediting rate, which are all guaranteed at issue.

(5) The one-year valuation premium means the net one-year premium based upon the original schedule of benefits for a given policy year. The one-year valuation premiums for all policy years are calculated at issue. The select mortality factors defined in section 3(b)(2) through 3(b)(4) of this rule may not be used to calculate the one-year valuation premiums.

(6) The one-year valuation premium should reflect the frequency of fund processing, as well as the distribution of deaths assumption employed in the calculation of the monthly mortality charges to the fund.

(b) Basic reserves for the secondary guarantees shall be the segmented reserves for the secondary guarantee period. In calculating the segments and the segmented reserves, the gross premiums shall be set equal to the specified premiums, if any, or otherwise to the minimum premiums, that keep the policy in force and the segments will be determined according to the contract segmentation method as defined in section 2(d) of this rule.

(c) Deficiency reserves, if any, for the secondary guarantees shall be calculated for the secondary guarantee period in the same manner as described in section (4)(b) of this rule with gross premiums set equal to the specified premiums, if any, or otherwise to the minimum premiums that keep the policy in force.

(d) The minimum reserves during the secondary guarantee period are the greater of:

(1) the basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees; or

(2) the minimum reserves required by other rules or regulations governing universal life plans.

(Department of Insurance; 760 IAC 1-64-5; filed Dec 1, 1999, 3:20 p.m.: 23 IR 802)

760 IAC 1-64-6 Tables of select mortality factors

Authority: IC 27-1-12-10.5
Affected: IC 27-1-12-10; IC 27-1-12-10.1

Sec. 6. (a) The tables of select mortality factors set forth in this section are the bases to which the respective percentage of section 3(a)(2), 3(b)(2), and 3(b)(3) of this rule are applied.

(b) The six (6) tables of select mortality factors contained in this section include:

(1) male, aggregate;

(2) male, nonsmoker;

(3) male, smoker;

(4) female, aggregate;

(5) female, nonsmoker; and

(6) female, smoker.

(c) The tables of select mortality factors set forth in this section apply to both age last birthday and age nearest birthday mortality tables.

(d) For sex-blended mortality tables, compute select mortality factors in the same proportion as the underlying mortality. For example, for the 1980 CSO-B Table, the calculated select mortality factors are eighty percent (80%) of the appropriate male table in this section, plus twenty percent (20%) of the appropriate female table in this section.

(e) The select mortality factors table for male, aggregate shall be as follows:

Male, Aggregate

Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	96	98	98	99	99	100	100	90	92	92	92	92	93	93	96	97	98	98	99	100
19	83	84	84	87	87	87	79	79	79	81	81	82	82	82	85	88	91	94	97	100
20	69	71	71	74	74	69	69	67	69	70	71	71	71	71	74	79	84	90	95	100
21	66	68	69	71	66	66	67	66	67	70	70	70	70	71	71	77	83	88	94	100
22	65	66	66	63	63	64	64	64	65	68	68	68	68	69	71	77	83	88	94	100
23	62	63	59	60	62	62	63	63	64	65	65	67	67	69	70	76	82	88	94	100
24	60	56	56	59	59	60	61	61	61	64	64	64	66	67	70	76	82	88	94	100
25	52	53	55	56	58	58	60	60	60	63	62	63	64	67	69	75	81	88	94	100
26	51	52	55	56	58	58	57	61	61	62	63	64	66	69	66	73	80	86	93	100
27	51	52	55	57	58	60	61	61	60	63	63	64	67	66	67	74	80	87	93	100
28	49	51	56	58	60	60	61	62	62	63	64	66	65	66	68	74	81	87	94	100
29	49	51	56	58	60	61	62	62	62	64	64	62	66	67	70	76	82	88	94	100
30	49	50	56	58	60	60	62	63	63	64	62	63	67	68	71	77	83	88	94	100
31	47	50	56	58	60	62	63	64	64	62	63	66	68	70	72	78	83	89	94	100
32	46	49	56	59	60	62	63	66	62	63	66	67	70	72	73	78	84	89	95	100
33	43	49	56	59	62	63	64	62	65	66	67	70	72	73	75	80	85	90	95	100
34	42	47	56	60	62	63	61	63	66	67	70	71	73	75	76	81	86	90	95	100
35	40	47	56	60	63	61	62	65	67	68	71	73	74	76	76	81	86	90	95	100
36	38	42	56	60	59	61	63	65	67	68	70	72	74	76	77	82	86	91	95	100
37	38	45	56	57	61	62	63	65	67	68	70	72	74	76	76	81	86	90	95	100
38	37	44	53	58	61	62	65	66	67	69	69	73	75	76	77	82	86	91	95	100
39	37	41	53	58	62	63	65	65	66	68	69	72	74	76	76	81	86	90	95	100
40	34	40	53	58	62	63	65	65	66	68	68	71	75	76	77	82	86	91	95	100
41	34	41	53	58	62	63	65	64	64	66	68	70	74	76	77	82	86	91	95	100
42	34	43	53	58	61	62	63	63	63	64	66	69	72	75	77	82	86	91	95	100

43	34	43	54	59	60	61	63	62	62	64	66	67	72	74	77	82	86	91	95	100
44	34	44	54	58	59	60	61	60	61	62	64	67	71	74	77	82	86	91	95	100
45	34	45	53	58	59	60	60	60	59	60	63	66	71	74	77	82	86	91	95	100
46	31	43	52	56	57	58	59	59	59	60	63	67	71	74	75	80	85	90	95	100
47	32	42	50	53	55	56	57	58	59	60	65	68	71	74	75	80	85	90	95	100
48	32	41	47	52	54	56	57	57	57	61	65	68	72	73	74	79	84	90	95	100
49	30	40	46	49	52	54	55	56	57	61	66	69	72	73	74	79	84	90	95	100
50	30	38	44	47	51	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
51	28	37	42	46	49	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
52	28	35	41	45	49	51	54	56	57	61	66	71	72	74	75	80	85	90	100	100
53	37	35	39	44	48	51	53	55	57	61	67	71	74	75	76	81	86	100	100	100
54	27	33	38	44	48	50	53	55	57	61	67	72	74	75	76	81	100	100	100	100
55	25	32	37	43	47	50	53	55	57	61	68	72	74	75	78	100	100	100	100	100
56	25	32	37	43	47	49	51	54	56	61	67	70	73	74	100	100	100	100	100	100
57	24	31	38	43	47	49	51	54	56	59	66	69	72	100	100	100	100	100	100	100
58	24	31	38	43	48	48	50	53	56	59	64	67	100	100	100	100	100	100	100	100
59	23	30	39	43	48	48	51	53	55	58	63	100	100	100	100	100	100	100	100	100
60	23	30	39	43	48	47	50	52	53	57	100	100	100	100	100	100	100	100	100	100
61	23	30	39	43	49	49	50	52	53	75	100	100	100	100	100	100	100	100	100	100
62	23	30	39	44	49	49	51	52	75	75	100	100	100	100	100	100	100	100	100	100
63	22	30	39	45	50	50	52	75	75	75	100	100	100	100	100	100	100	100	100	100
64	22	30	39	45	50	51	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	22	30	39	45	50	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	22	30	39	45	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	22	30	39	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	23	32	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	23	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	10	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

(f) The select mortality factors table for male, nonsmoker shall be as follows:

Male, Nonsmoker

Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	93	95	96	98	99	100	100	90	92	92	92	92	95	95	96	97	98	98	99	100
19	80	81	83	86	87	87	79	79	79	81	81	82	83	83	86	89	92	94	97	100
20	65	68	69	72	74	69	69	67	69	70	71	71	72	72	75	80	85	90	95	100
21	63	66	68	71	66	66	67	66	67	70	70	70	71	71	73	78	84	89	95	100
22	62	65	66	62	63	64	64	64	67	68	68	68	70	70	73	78	84	89	95	100
23	60	62	58	60	62	62	63	63	64	67	68	68	67	69	71	77	83	88	94	100
24	59	55	56	58	59	60	61	61	63	65	67	66	66	69	71	77	83	88	94	100
25	52	53	55	56	58	58	60	60	61	64	64	64	64	67	70	76	82	88	94	100
26	51	53	55	56	58	60	61	61	61	63	64	64	66	69	67	74	80	87	93	100
27	51	52	55	58	60	60	61	61	62	63	64	66	67	66	67	74	80	87	93	100
28	49	52	57	58	60	61	63	62	62	64	66	66	63	66	68	74	81	87	94	100
29	49	51	57	60	61	61	62	62	63	64	66	63	65	67	68	74	81	87	94	100
30	49	51	57	60	61	62	63	63	63	64	62	63	66	68	70	76	82	88	94	100
31	47	50	57	60	60	62	63	64	64	62	63	65	67	70	71	77	83	88	94	100
32	46	50	57	60	62	63	64	64	62	63	65	66	68	71	72	78	83	89	94	100
33	45	49	56	60	62	63	64	62	63	65	66	68	71	73	74	79	84	90	95	100
34	43	48	56	62	63	64	62	62	65	66	67	70	72	74	74	79	84	90	95	100
35	41	47	56	62	63	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
36	40	47	56	62	59	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
37	38	45	56	58	59	61	62	63	66	67	67	69	71	73	74	79	84	90	95	100
38	38	45	53	58	61	62	63	65	65	67	68	70	72	74	73	78	84	89	95	100
39	37	41	53	58	61	62	63	64	65	67	68	70	71	73	73	78	84	89	95	100
40	34	41	53	58	61	62	63	64	64	66	67	69	71	73	72	78	83	89	94	100
41	34	41	53	58	61	61	62	62	63	65	65	67	69	71	71	77	83	88	94	100
42	34	43	53	58	60	61	62	61	61	63	64	66	67	69	71	77	83	88	94	100
43	32	43	53	58	60	61	60	60	60	60	62	64	66	68	69	75	81	88	94	100
44	32	44	52	57	59	60	60	59	59	58	60	62	65	67	69	75	81	88	94	100
45	32	44	52	57	59	60	59	57	57	57	59	61	63	66	68	74	81	87	94	100
46	32	42	50	54	56	57	57	56	55	56	59	61	63	65	67	74	80	87	93	100
47	30	40	48	52	54	55	55	54	54	55	59	61	62	63	66	73	80	86	93	100
48	30	40	46	49	51	52	53	53	54	55	57	61	62	63	63	70	78	85	93	100
49	29	39	43	48	50	51	50	51	53	54	57	61	61	62	62	70	77	85	92	100
50	29	37	42	45	47	48	49	50	51	54	57	61	61	61	61	69	77	84	92	100
51	27	35	40	43	45	47	48	50	51	53	57	60	61	61	62	70	77	85	92	100
52	27	34	39	42	44	45	48	49	50	53	56	60	60	62	62	70	77	85	100	100
53	25	31	37	41	44	45	47	49	50	51	56	59	61	61	62	70	77	100	100	100
54	25	30	36	39	43	44	47	48	49	51	55	59	59	61	62	70	100	100	100	100
55	24	29	35	38	42	43	45	48	49	50	56	58	59	61	62	100	100	100	100	100

56	23	29	35	38	42	42	44	47	48	50	55	57	58	59	100	100	100	100	100	100
57	23	28	35	38	42	42	43	45	47	49	53	55	56	100	100	100	100	100	100	100
58	22	28	33	37	41	41	43	45	45	47	51	53	100	100	100	100	100	100	100	100
59	22	26	33	37	41	41	42	44	44	46	50	100	100	100	100	100	100	100	100	100
60	20	26	33	37	41	40	41	42	42	45	100	100	100	100	100	100	100	100	100	100
61	20	26	33	37	41	40	41	42	42	75	100	100	100	100	100	100	100	100	100	100
62	19	25	32	38	40	40	41	42	75	75	100	100	100	100	100	100	100	100	100	100
63	19	25	33	36	40	40	41	75	75	75	100	100	100	100	100	100	100	100	100	100
64	18	24	32	36	39	40	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	18	24	32	36	39	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	18	24	32	36	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	18	24	32	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	18	24	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	18	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

(g) The select mortality factors table for male, smoker shall be as follows:

Male, Smoker

Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
19	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
20	98	100	100	100	100	100	100	99	99	99	100	99	99	99	100	100	100	100	100	100
21	95	98	99	100	95	96	96	95	96	97	97	96	96	96	96	97	98	98	99	100
22	92	95	96	90	90	93	93	92	93	95	95	93	93	92	93	94	96	97	99	100
23	90	92	85	88	88	89	89	89	90	90	90	90	89	90	92	94	95	97	98	100
24	87	81	82	85	84	86	88	86	86	88	88	86	86	88	89	91	93	96	98	100
25	77	78	79	82	81	83	83	82	83	85	84	84	84	85	86	89	92	94	97	100

26	75	77	79	82	82	83	83	82	83	84	84	84	84	85	81	85	89	92	96	100
27	73	75	78	82	82	83	83	82	82	82	82	84	84	80	81	85	89	92	96	100
28	71	73	79	82	81	82	83	81	81	82	82	82	80	80	81	85	89	92	96	100
29	69	72	78	81	81	82	82	81	81	81	81	77	80	80	81	85	89	92	96	100
30	68	71	78	81	81	81	82	81	81	81	76	77	80	80	81	85	89	92	96	100
31	65	70	77	81	79	81	82	81	81	76	77	79	81	81	83	86	90	93	97	100
32	63	67	77	78	79	81	81	81	76	77	77	80	83	83	85	88	91	94	97	100
33	60	65	74	78	79	79	81	76	77	77	79	80	83	85	85	88	91	94	97	100
34	57	62	74	77	79	79	75	76	77	79	79	81	83	85	87	90	92	95	97	100
35	53	60	73	77	79	75	75	76	77	79	80	82	84	86	88	90	93	95	98	100
36	52	59	71	75	74	75	75	76	77	79	79	81	83	85	87	90	92	95	97	100
37	49	58	70	71	74	74	75	76	77	78	79	81	84	86	86	89	92	94	97	100
38	48	55	66	70	72	74	74	75	76	78	79	81	83	85	87	90	92	95	97	100
39	45	50	65	70	72	72	74	74	75	77	79	81	84	86	86	89	92	94	97	100
40	41	49	63	68	71	72	73	74	74	76	78	80	83	85	86	89	92	94	97	100
41	40	49	63	68	71	72	72	72	73	75	76	78	81	84	85	88	91	94	97	100
42	40	49	62	68	70	71	71	71	71	73	75	76	81	83	85	88	91	94	97	100
43	39	50	62	67	69	69	70	70	70	71	73	76	79	83	85	88	91	94	97	100
44	39	50	60	66	68	69	68	69	69	69	71	74	79	81	85	88	91	94	97	100
45	37	50	60	66	68	68	68	67	67	67	69	73	78	81	85	88	91	94	97	100
46	37	48	58	63	65	67	66	66	66	67	71	74	78	81	84	87	90	94	97	100
47	36	47	55	61	63	64	64	64	65	67	71	75	79	81	84	87	90	94	97	100
48	35	46	53	58	60	62	63	63	65	67	72	75	79	81	83	86	90	93	97	100
49	34	45	51	56	58	59	61	62	63	67	72	77	80	81	83	86	90	93	97	100
50	34	43	49	53	55	57	60	61	63	67	73	78	80	81	81	85	89	92	96	100
51	32	42	47	52	55	57	60	61	63	67	73	78	80	83	84	87	90	94	97	100
52	32	40	46	50	54	56	60	61	63	67	73	78	81	84	85	88	91	94	100	100
53	30	37	44	49	54	56	59	61	65	67	74	79	83	85	87	90	92	100	100	100
54	30	36	43	48	53	55	59	61	65	67	74	80	84	85	89	91	100	100	100	100
55	29	35	42	47	53	55	59	61	65	67	75	80	84	86	90	100	100	100	100	100
56	28	35	42	47	53	55	57	60	63	68	74	79	83	85	100	100	100	100	100	100
57	28	35	42	47	53	54	57	60	64	67	74	78	81	100	100	100	100	100	100	100
58	26	33	43	48	54	54	56	59	63	67	73	78	100	100	100	100	100	100	100	100
59	26	33	43	48	54	53	57	59	63	66	73	100	100	100	100	100	100	100	100	100
60	25	33	43	48	54	53	56	58	62	66	100	100	100	100	100	100	100	100	100	100
61	25	33	43	49	55	55	57	59	63	75	100	100	100	100	100	100	100	100	100	100
62	25	33	43	50	56	56	58	61	75	75	100	100	100	100	100	100	100	100	100	100
63	24	33	45	51	56	56	59	75	75	75	100	100	100	100	100	100	100	100	100	100
64	24	34	45	51	57	57	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	24	34	45	52	57	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	24	35	45	53	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	25	35	45	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	25	36	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	27	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

(h) The select mortality factors table for female, aggregate shall be as follows:

Female, Aggregate

Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	99	100	100	100	100	100	100	100	93	95	96	97	97	100	100	100	100	100	100	100
18	83	83	84	84	84	84	86	78	78	79	82	84	85	88	88	90	93	95	98	100
19	65	66	68	68	68	68	63	63	64	66	69	71	72	74	75	80	85	90	95	100
20	48	50	51	51	51	47	48	48	49	51	56	57	58	61	63	70	78	85	93	100
21	47	48	50	51	47	47	48	49	51	53	57	60	61	64	64	71	78	86	93	100
22	44	47	48	45	47	47	48	49	53	54	60	61	63	64	66	73	80	86	93	100
23	42	45	44	45	47	47	49	51	53	54	61	64	64	67	69	75	81	88	94	100
24	39	40	42	44	47	47	50	51	54	56	64	64	66	69	70	76	82	88	94	100
25	34	38	41	44	47	47	50	53	56	57	64	67	69	71	73	78	84	89	95	100
26	34	38	41	45	49	49	51	56	58	59	66	69	70	73	70	76	82	88	94	100
27	34	38	41	47	50	51	54	57	59	60	69	70	73	70	71	77	83	88	94	100
28	34	37	43	47	53	53	56	59	62	63	70	73	70	72	74	79	84	90	95	100
29	34	38	43	49	54	56	58	60	63	64	73	70	72	74	75	80	85	90	95	100
30	35	38	43	50	56	56	59	63	66	67	70	71	74	75	76	81	86	90	95	100
31	35	38	43	51	56	58	60	64	67	65	71	72	74	75	76	81	86	90	95	100
32	35	39	45	51	56	59	63	66	65	66	72	72	75	76	76	81	86	90	95	100
33	36	39	44	52	58	62	64	65	66	67	72	74	75	76	76	81	86	90	95	100
34	36	40	45	52	58	63	63	66	67	68	74	74	76	76	76	81	86	90	95	100
35	36	40	45	53	59	61	65	67	68	70	75	74	75	76	75	80	85	90	95	100
36	36	40	45	53	55	62	65	67	68	70	74	74	74	75	75	80	85	90	95	100
37	36	41	47	52	57	62	65	67	68	69	72	72	73	75	74	79	84	90	95	100
38	34	41	44	52	57	63	66	68	69	70	72	71	72	74	75	80	85	90	95	100
39	34	40	45	53	58	63	66	68	69	69	70	70	70	73	74	79	84	90	95	100

40	32	40	45	53	58	65	65	67	68	69	70	69	70	73	73	78	84	89	95	100
41	32	40	45	53	57	63	64	67	68	68	69	69	69	73	74	79	84	90	95	100
42	32	40	45	52	56	61	63	65	66	68	69	68	70	74	75	80	85	90	95	100
43	31	39	45	51	55	59	61	65	65	66	68	69	69	74	77	82	86	91	95	100
44	31	39	45	50	54	58	61	63	64	66	67	68	71	75	78	82	87	91	96	100
45	31	38	44	49	53	56	59	62	63	65	67	68	71	77	79	83	87	92	96	100
46	29	37	43	48	51	54	59	62	63	65	67	69	71	77	78	82	87	91	96	100
47	28	35	41	46	49	54	57	61	62	66	68	69	71	77	77	82	86	91	95	100
48	28	35	41	44	49	52	57	61	63	66	68	71	72	75	77	82	86	91	95	100
49	26	34	39	43	47	52	55	61	63	67	69	71	72	75	75	80	85	90	95	100
50	25	32	38	41	46	50	55	61	63	67	69	72	72	75	74	79	84	90	95	100
51	25	32	38	41	45	50	55	61	63	66	68	69	71	74	74	79	84	90	95	100
52	23	30	36	41	45	51	56	61	62	65	66	68	68	73	73	78	84	89	100	100
53	23	30	36	41	47	51	56	61	62	63	65	66	68	72	72	78	83	100	100	100
54	22	29	35	41	47	53	57	61	61	62	62	66	66	69	70	76	100	100	100	100
55	22	29	35	41	47	53	57	61	61	61	62	63	64	68	69	100	100	100	100	100
56	22	29	35	41	45	51	56	59	60	61	62	63	64	67	100	100	100	100	100	100
57	22	29	35	41	45	50	54	56	58	59	61	62	63	100	100	100	100	100	100	100
58	22	30	36	41	44	49	53	56	57	57	61	62	100	100	100	100	100	100	100	100
59	22	30	36	41	44	48	51	53	55	56	59	100	100	100	100	100	100	100	100	100
60	22	30	36	41	43	47	50	51	53	55	100	100	100	100	100	100	100	100	100	100
61	22	29	35	39	42	46	49	50	52	80	100	100	100	100	100	100	100	100	100	100
62	20	28	33	39	41	45	47	49	80	80	100	100	100	100	100	100	100	100	100	100
63	20	28	33	38	41	44	46	80	80	80	100	100	100	100	100	100	100	100	100	100
64	19	27	32	36	40	42	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	19	25	30	35	39	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	19	25	30	35	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	19	25	30	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	19	25	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	19	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

(i) The select mortality factors table for female, nonsmoker shall be as follows:

Female, Nonsmoker

Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	96	98	98	98	98	99	99	99	92	92	93	95	95	97	99	99	99	100	100	100
18	78	80	80	80	80	81	81	74	75	75	78	79	82	83	85	88	91	94	97	100
19	60	62	63	63	63	65	59	59	60	60	64	67	67	70	72	78	83	89	94	100
20	42	44	45	45	45	42	42	42	45	45	50	51	53	56	58	66	75	83	92	100
21	41	42	44	45	41	42	42	44	47	47	51	53	54	57	59	67	75	84	92	100
22	39	41	44	41	41	42	44	45	49	49	54	56	57	58	60	68	76	84	92	100
23	38	41	38	40	41	42	44	46	49	50	56	57	58	60	62	70	77	85	92	100
24	36	36	38	40	41	42	46	47	50	51	58	59	60	62	63	70	78	85	93	100
25	32	34	37	40	41	43	46	49	51	53	59	60	62	63	64	71	78	86	93	100
26	32	34	37	41	43	45	47	50	53	53	60	62	63	64	62	70	77	85	92	100
27	32	34	38	43	46	47	49	51	53	55	62	63	64	62	62	70	77	85	92	100
28	30	34	39	43	47	49	51	53	56	58	63	63	61	62	63	70	78	85	93	100
29	30	35	40	45	50	51	52	55	58	59	64	61	62	63	63	70	78	85	93	100
30	31	35	40	46	51	52	53	56	59	60	62	62	63	65	65	72	79	86	93	100
31	31	35	40	46	51	53	55	58	60	58	62	62	63	65	65	72	79	86	93	100
32	32	35	40	45	51	53	56	59	57	58	62	63	63	65	64	71	78	86	93	100
33	32	36	41	47	52	55	58	55	58	59	63	63	65	65	65	72	79	86	93	100
34	33	36	41	47	52	55	55	57	58	59	63	65	64	65	64	71	78	86	93	100
35	33	36	41	47	52	53	57	58	59	61	63	64	64	64	64	71	78	86	93	100
36	33	36	41	47	49	53	57	58	59	61	63	64	63	64	63	70	78	85	93	100
37	32	36	41	44	49	53	57	58	59	60	62	62	61	62	63	70	78	85	93	100
38	32	37	39	45	50	54	57	58	60	60	61	61	61	62	61	69	77	84	92	100
39	30	35	39	45	50	54	57	58	60	59	60	60	59	60	61	69	77	84	92	100
40	28	35	39	45	50	54	56	57	59	59	60	59	59	59	60	68	76	84	92	100
41	28	35	39	45	49	52	55	55	58	57	58	59	58	59	60	68	76	84	92	100
42	27	35	39	44	49	52	54	55	56	57	57	57	58	60	61	69	77	84	92	100
43	27	34	39	44	47	50	53	53	55	55	56	57	56	60	61	69	77	84	92	100
44	26	34	38	42	47	50	52	53	54	55	55	55	56	61	62	70	77	85	92	100
45	26	33	38	42	45	48	51	51	52	53	54	55	56	61	62	70	77	85	92	100
46	24	32	37	40	43	47	49	51	52	53	54	55	56	60	61	69	77	84	92	100
47	24	30	35	39	42	45	47	49	51	53	54	55	56	59	60	68	76	84	92	100
48	23	30	35	37	40	44	47	49	50	53	54	55	55	59	57	66	74	83	91	100
49	23	29	33	35	39	42	45	48	50	53	54	55	55	57	56	65	74	82	91	100
50	21	27	32	34	37	41	44	48	50	53	54	55	55	56	55	64	73	82	91	100
51	21	26	30	34	37	41	44	48	49	51	53	53	54	55	55	64	73	82	91	100
52	20	25	30	33	37	41	44	47	48	50	50	51	51	55	53	62	72	81	100	100
53	19	24	29	32	37	41	43	47	48	48	49	49	51	52	52	62	71	100	100	100

54	18	24	29	32	37	41	43	45	47	47	47	49	49	51	51	61	100	100	100	100
55	18	23	28	32	37	41	43	45	45	45	46	46	47	50	50	100	100	100	100	100
56	18	23	28	32	36	39	42	44	44	45	46	46	46	49	100	100	100	100	100	100
57	18	23	28	31	35	38	41	42	44	44	45	45	46	100	100	100	100	100	100	100
58	17	23	26	31	35	36	38	41	41	42	45	45	100	100	100	100	100	100	100	100
59	17	23	26	30	33	35	38	39	40	41	44	100	100	100	100	100	100	100	100	100
60	17	23	26	30	32	34	36	38	39	40	100	100	100	100	100	100	100	100	100	100
61	17	22	25	29	32	33	35	36	38	80	100	100	100	100	100	100	100	100	100	100
62	16	22	25	28	30	32	34	35	80	80	100	100	100	100	100	100	100	100	100	100
63	16	20	24	28	30	32	34	80	80	80	100	100	100	100	100	100	100	100	100	100
64	14	21	24	27	29	30	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	15	19	23	25	28	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	15	19	23	25	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	15	19	22	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	13	18	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	13	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

(j) The select mortality factors table for tables for female, smoker shall be as follows:

Female, Smoker

Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	99	100	100	100	100	100	100	95	96	97	100	100	100	100	100	100	100	100	100	100
19	87	89	92	92	92	92	84	84	86	86	92	93	95	96	99	99	99	100	100	100
20	74	77	80	80	80	73	73	73	75	77	83	83	86	88	90	92	94	96	98	100
21	71	74	78	78	71	71	73	74	77	79	85	86	88	89	90	92	94	96	98	100
22	68	71	75	70	71	71	73	74	78	79	88	90	89	89	92	94	95	97	98	100
23	65	69	67	70	70	70	73	77	79	81	89	90	90	92	92	94	95	97	98	100

24	62	60	64	69	70	70	74	77	79	81	92	90	92	93	93	94	96	97	99	100
25	53	58	63	67	69	70	74	78	81	82	92	93	93	95	95	96	97	98	99	100
26	53	58	63	69	71	72	75	79	82	82	93	93	95	96	90	92	94	96	98	100
27	52	56	63	70	74	74	78	81	82	84	93	95	95	90	90	92	94	96	98	100
28	52	56	64	71	75	77	79	82	85	86	95	95	90	92	92	94	95	97	98	100
29	51	56	64	71	78	78	81	84	86	88	95	90	90	92	92	94	95	97	98	100
30	51	56	64	72	79	79	82	85	88	89	90	90	92	93	93	94	96	97	99	100
31	51	56	64	72	78	81	84	84	88	84	90	90	92	93	93	94	96	97	99	100
32	51	56	64	71	78	81	85	86	84	85	90	90	92	94	93	94	96	97	99	100
33	51	57	62	71	78	82	85	83	84	85	90	92	93	93	93	94	96	97	99	100
34	51	56	62	71	78	82	81	83	85	86	90	92	92	94	93	94	96	97	99	100
35	51	56	62	71	78	79	83	84	85	86	90	91	91	93	93	94	96	97	99	100
36	49	56	62	71	74	79	83	84	85	86	90	90	91	93	92	94	95	97	98	100
37	48	55	62	67	74	79	83	84	85	86	89	90	89	92	91	93	95	96	98	100
38	47	55	57	66	72	77	81	84	86	86	87	88	88	90	91	93	95	96	98	100
39	45	50	57	66	72	77	81	83	85	86	86	87	86	89	90	92	94	96	98	100
40	41	50	57	66	72	77	81	83	84	85	86	86	86	89	89	91	93	96	98	100
41	40	50	57	65	71	76	79	81	83	84	85	86	85	89	90	92	94	96	98	100
42	40	49	57	65	69	74	77	80	82	83	84	85	86	90	92	94	95	97	98	100
43	39	49	55	63	69	73	76	78	80	82	83	84	85	92	93	94	96	97	99	100
44	39	48	55	62	67	71	75	78	80	80	82	84	86	93	96	97	98	98	99	100
45	37	47	55	61	65	70	73	76	78	80	81	84	86	94	97	98	98	99	99	100
46	36	46	53	59	63	68	71	75	77	79	83	85	86	93	96	97	98	98	99	100
47	34	44	51	57	62	66	70	75	77	80	83	85	86	93	94	95	96	98	99	100
48	34	44	50	54	60	64	69	74	77	80	84	86	87	92	92	94	95	97	98	100
49	33	42	48	53	58	63	68	74	77	81	84	86	87	92	91	93	95	96	98	100
50	31	41	46	51	57	61	67	74	77	81	85	87	87	91	90	92	94	96	98	100
51	30	39	45	51	56	61	67	74	75	80	83	85	85	90	90	92	94	96	98	100
52	29	38	45	50	56	62	68	74	75	79	81	83	84	90	90	92	94	96	100	100
53	28	37	43	49	57	62	68	73	74	77	79	81	83	89	89	91	93	100	100	100
54	28	36	43	49	57	63	69	73	74	75	78	80	81	87	89	91	100	100	100	100
55	26	35	42	49	57	63	69	73	73	74	76	78	79	86	87	100	100	100	100	100
56	26	35	42	49	56	62	67	71	72	74	76	78	79	85	100	100	100	100	100	100
57	26	35	42	49	55	61	66	69	72	73	76	78	79	100	100	100	100	100	100	100
58	28	36	43	49	55	59	63	68	69	72	76	78	100	100	100	100	100	100	100	100
59	28	36	43	49	54	57	63	67	68	70	76	100	100	100	100	100	100	100	100	100
60	28	36	43	49	53	57	61	64	67	69	100	100	100	100	100	100	100	100	100	100
61	26	35	42	48	52	56	59	63	66	80	100	100	100	100	100	100	100	100	100	100
62	26	33	41	47	51	55	58	62	80	80	100	100	100	100	100	100	100	100	100	100
63	25	33	41	46	51	55	57	80	80	80	100	100	100	100	100	100	100	100	100	100
64	25	33	40	45	50	53	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	24	32	39	44	49	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	24	32	39	44	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	24	32	39	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	24	32	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	24	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

(Department of Insurance; 760 IAC 1-64-6; filed Dec 1, 1999, 3:20 p.m.: 23 IR 803)

Rule 65. Annual Report of Sales to Exempt Commercial Policyholders Required by IC 27-1-22-4(n)

760 IAC 1-65-1 Scope

Authority: IC 27-1-22-4
Affected: IC 27-1-3-15; IC 27-1-22-2.5

Sec. 1. (a) Each insurer who issues insurance to an exempt commercial policyholder as defined in IC 27-1-22-2.5 shall file an annual report with the department of insurance by February 1 of each year.

(b) The first report shall be filed by February 1, 2000, to report information for the period July 1, 1999, to December 31, 1999. Subsequent annual reports shall report information for the period January 1 to December 31 of the previous year.

(c) The report shall be accompanied by the fee prescribed by IC 27-1-3-15(e). For purposes of calculating the required fee, each policy purchased by an exempt commercial policyholder shall be considered a product filing under IC 27-1-3-15(e).

(d) The format for and elements of the annual report are set forth in section 2 of this rule. The required information must be reported for each exempt commercial policyholder. The report may not disclose the identity of an exempt commercial policyholder.

(e) The policyholder identification number may be any number used by the insurer to identify the exempt commercial policyholder.

(f) For purposes of completing the information required by Item 4 of the annual report, the list of criteria is as follows:

(1) Net worth of more than twenty-five million dollars ($25,000,000) at the time the policy of insurance was issued.

(2) Net revenue or sales of more than fifty million dollars ($50,000,000) in the preceding fiscal year.

(3) More than twenty-five (25) employees per individual company or fifty (50) employees per holding company aggregate at the time the policy of insurance was issued.

(4) Aggregate annual net commercial insurance premiums, excluding any worker's compensation and professional liability insurance premiums, of more than seventy-five thousand dollars ($75,000) in the preceding fiscal year.

(5) Is a nonprofit or a public entity with an annual budget of at least twenty-five million dollars ($25,000,000) or assets of at least twenty-five million dollars ($25,000,000) in the preceding fiscal year.

(6) Procures commercial insurance with the services of a risk manager as defined in IC 27-1-22-2.5(b).

(Department of Insurance; 760 IAC 1-65-1; filed Dec 16, 1999, 4:27 p.m.: 23 IR 1105)

760 IAC 1-65-2 Annual report of sales to exempt commercial policyholders

Authority: IC 27-1-22-4
Affected: IC 27-1-22-4

Sec. 2. The format for and elements of the annual report are as follows:

REPORT ON SALES TO EXEMPT COMMERCIAL POLICYHOLDERS

Insurer name: _____

State of domicile: _____

NAIC number: _____

Reporting period: _____

Policyholder identification number: _____

Complete requested information for each commercial insurance policy, excluding worker's compensation and professional liability insurance, sold to the exempt commercial policyholder during the reporting period:	1. Annual net policy premium:	2. Inception date and expiration date of the policy:	3. List by number each criterion from 760 IAC 1-65-1(f) that was used to establish the insured as an exempt commercial policyholder (must include at least three criteria for each policyholder):
Policy:		Inception: Expiration:	
Policy:		Inception: Expiration:	
Policy:		Inception: Expiration:	
Policy:		Inception: Expiration:	

Fee submitted _____ (# of policies, excluding worker's compensation and professional liability insurance multiplied by Indiana product filing fee equal to the greater of $35 or home state product filing fee for property/casualty filing)

Signature: _____

Printed name and title: _____

_____

Phone number: _____

E-mail address: _____

(Department of Insurance; 760 IAC 1-65-2; filed Dec 16, 1999, 4:27 p.m.: 23 IR 1105)

Rule 66. Acquisition of Shares of Former Mutual Insurance Company by Institutional Investor

760 IAC 1-66-1 Applicability and scope

Authority: IC 27-15-13-2

Affected: IC 27-15-13-2

Sec. 1. (a) This rule is intended to provide a procedure under which an institutional investor may acquire beneficial ownership of five percent (5%) or more, but less than ten percent (10%) of the outstanding shares of any class of a voting security of a former mutual or any parent company, in a manner considered to have been approved by the commissioner under IC 27-15-13-2.

(b) This rule applies to acquisitions of shares by institutional investors that are not affiliates of the former mutual or parent company and that are acting in the ordinary course of business and not with the purpose or effect of changing or influencing the control, management, or policies of the former mutual or parent company. *(Department of Insurance; 760 IAC 1-66-1; filed Aug 3, 2001, 4:38 p.m.: 24 IR 3985)*

760 IAC 1-66-2 Definitions

Authority: IC 27-15-13-2
Affected: IC 27-1-2-3; IC 27-1-23-1; IC 27-15-1; IC 27-15-13-1

Sec. 2. The definitions set forth in IC 27-1-2-3, IC 27-1-23-1, and IC 27-15-1 and the following definitions apply throughout this rule:

(1) "Conversion" means the conversion of a former mutual company pursuant to a plan of conversion.

(2) "Executive officer" means any individual charged with active management and control in an executive capacity, including a president, vice president, treasurer, secretary, controller, or any other individual performing functions corresponding to those performed by the foregoing officers, of a person whether incorporated or unincorporated.

(3) "Institutional investor" means any of the following, whether acting for its own account or the accounts of other institutional investors:

(A) A depository institution, including a bank, federal savings bank, savings and loan association, or trust company, regulated and supervised under the laws of the United States or any state.

(B) An insurance company.

(C) A separate account of an insurance company.

(D) An investment company registered under the federal "Investment Company Act of 1940", 15 U.S.C. §§ 80a-1 et seq.

(E) A business development company as defined in the federal "Investment Company Act of 1940", 15 U.S.C. § 80a-2(48).

(F) Any private business development company as defined in the federal "Investment Advisers Act of 1940", 15 U.S.C. § 80b-2(22).

(G) An employee pension, profit-sharing, or benefit plan if the plan has total assets in excess of twenty-five million dollars ($25,000,000) or its investment decisions are made by a named fiduciary, as defined in the federal "Employee Retirement Income Security Act of 1974", 29 U.S.C. § 1002(21), that is a broker-dealer registered under the federal "Securities Exchange Act of 1934", 15 U.S.C. § 78o, an investment adviser registered or exempt from registration under the federal "Investment Advisers Act of 1940", 15 U.S.C. § 80b-3, a depository institution, or an insurance company.

(H) An entity, but not an individual, a substantial part of whose business activities consist of investing, purchasing, selling, or trading in securities of more than one (1) issuer and not of its own issue and that has total assets in excess of fifty million dollars ($50,000,000) as of the end of its latest fiscal year and in the aggregate owns and invests on a discretionary basis at least ten million dollars ($10,000,000) of securities of issuers with which it is not affiliated.

(I) A small business investment company licensed under the federal "Small Business Investment Act of 1958", 15 U.S.C. § 681.

(J) Any other qualified institutional buyer as defined in Rule 144A(a)(1) of the Securities and Exchange Commission or any successor regulation.

The term shall not include the former mutual company, any parent company, or any employee benefit plan or trusts sponsored by the former mutual or a parent company where no approval under IC 27-15-13-1 is required.

(Department of Insurance; 760 IAC 1-66-2; filed Aug 3, 2001, 4:38 p.m.: 24 IR 3985)

760 IAC 1-66-3 General requirements

Authority: IC 27-15-13-2
Affected: IC 27-15-13

Sec. 3. (a) Not less than ten (10) business days, or such shorter time period as the commissioner may permit, prior to an institutional investor directly or indirectly acquiring, or agreeing or offering to acquire in any manner the beneficial ownership of five percent (5%) or more but less than ten percent (10%) of the outstanding shares of any class of a voting security of the former mutual or any parent company within five (5) years of the effective date of a conversion, the following certificates and documents shall be filed with the commissioner:

(1) A certificate, signed by the president and the secretary or other executive officers of the former mutual company and any parent company, in the form provided in section 6 of this rule.

(2) A certificate, signed by two (2) executive officers of the institutional investor, in the form provided in section 7 of this rule.

(3) Copies of any filings made or received by the former mutual company, parent company, or institutional investor with the Securities and Exchange Commission relating to the proposed acquisition of the shares.

(4) A copy of any agreement by the institutional investor or any affiliate thereof and the parent company, former mutual company, or any affiliate thereof concerning the shares or the voting thereof.

(b) Each certificate shall be signed and dated within ten (10) business days prior to the filing. The certificates shall be attached and submitted by the former mutual company as a single filing along with a cover letter explaining the purpose of the filing.

(c) The former mutual company shall file one (1) originally signed copy and two (2) photocopies of the certificates, other documents, and cover letter. The filing shall be made by personal delivery or first class mail addressed to: Department of Insurance, Attention: Chief Examiner, 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204. *(Department of Insurance; 760 IAC 1-66-3; filed Aug 3, 2001, 4:38 p.m.: 24 IR 3986)*

760 IAC 1-66-4 Review of filings

Authority: IC 27-15-13-2
Affected: IC 27-1-23-2; IC 27-15-13

Sec. 4. (a) A filing made by a former mutual company in accordance with section 3 of this rule shall be deemed approved by the commissioner as of the date the department receives the filing.

(b) The commissioner may review filings made under this rule at any time within thirty (30) days after receipt and may issue a written request for a former mutual company, parent company, or institutional investor to provide any additional information that may be appropriate to complete such review. The commissioner may, at the same time, order the institutional investor to refrain from purchasing any shares that, together with shares already beneficially owned by the institutional investor, would give the institutional investor ownership of five percent (5%) or more of the outstanding shares of any class of voting securities of the former mutual or parent company. The order shall remain in effect until the earliest of the following:

(1) Sixty (60) days following the date the commissioner received the filing.

(2) The date the commissioner makes a determination under subsection (c).

(3) The date the commissioner otherwise provides the former mutual company and the institutional investor with a written approval for the acquisition of shares to resume.

(c) The commissioner may disapprove any acquisition of shares made or to be made under this rule only after furnishing the former mutual company, parent company, and institutional investor with notice and an opportunity to comment or object within thirty (30) days after the commissioner's receipt of the filing made by the former mutual company. The commissioner may disapprove any acquisition of shares if the commissioner finds any of the following:

(1) The filing is or was preceded by any filing that was false, omitted material facts, was materially deficient, or otherwise does not comply with the requirements of section 3 of this rule.

(2) Would not satisfy the requirements of IC 27-1-23-2(e).

(3) Would frustrate the plan of conversion or the amendment to the articles of incorporation as approved by the members of the former mutual company and the commissioner.

(4) Was not approved by the boards of directors of the former mutual company and any parent company.

(5) Would not be in the best interest of the policyholders of the former mutual company, without regard to any interest of policyholders as shareholders of the former mutual company or any parent company.

(d) If the commissioner disapproves an acquisition of shares made or to be made under this rule, the institutional investor may not, after the date of the disapproval, acquire any shares that, together with shares already beneficially owned by the institutional investor, would give the institutional investor five percent (5%) or more of the outstanding shares of any class of voting securities of the former mutual or parent company. The commissioner shall provide written notice of disapproval, including the reason for disapproval to the former mutual company, parent company, and institutional investor promptly after the finding of disapproval. The commissioner may also order the institutional investor to divest itself of all shares of the former mutual company or parent company that equal or exceed five percent (5%) of the shares of any class of voting securities of the former mutual company or parent company. The institutional investor must complete the divestiture within sixty (60) days after the commissioner's order to divest unless the commissioner specifies a longer period of time. *(Department of Insurance; 760 IAC 1-66-4; filed Aug 3, 2001, 4:38 p.m.: 24 IR 3986)*

760 IAC 1-66-5 Additional powers of commissioner; prohibition from use of rule based on change in investor's certificate

Authority: IC 27-15-13-2
Affected: IC 27-1-23

Sec. 5. (a) Nothing in this rule shall prevent the commissioner from taking any action necessary for the protection of the policyholders of the former mutual company upon the commissioner's receipt of a notice of any change in the matters certified as required by IC 27-15-13-2(b)(2)(C).

(b) An institutional investor that files a notice described in subsection (a) may make no further acquisitions of shares under this rule if any change reported in such notice would:

(1) make the institutional investor ineligible to use this rule to acquire shares;

(2) require approval under IC 27-1-23; or

(3) otherwise cause the commissioner to disapprove an acquisition of shares.

(Department of Insurance; 760 IAC 1-66-5; filed Aug 3, 2001, 4:38 p.m.: 24 IR 3987)

760 IAC 1-66-6 Certificate of officers of former mutual and parent company

Authority: IC 27-15-13-2
Affected: IC 27-15

Sec. 6. The certificate required under section 3 of this rule from the officers of the former mutual company and any parent company shall be in the following form:

OFFICERS' CERTIFICATE
Regarding the Proposed Acquisition of Shares of the
Voting Securities of a Former Mutual Insurance
Company or Parent Company
Filed with the
INDIANA INSURANCE COMMISSIONER
By

_____
[Name of Former Mutual Company and any
Parent Company]
A Former Mutual Insurance Company
[and Parent Company]
Filing in Support of the Acquisition
of 5% or more, but less than 10% of Shares by
[Name of Institutional Investor],
an Institutional Investor under 760 IAC 1-66-2

organized in the State of _____
On its [their] Own Behalf
Name, title, address, and telephone number
of individuals to whom notices and correspondence
concerning this Certificate should be addressed:

_____
_____
_____
_____

Officers' Certificate

We, [names of President and Secretary of former mutual or other executive officers], as the [titles of executive officers], respectively, of [insert name of former mutual company], an Indiana stock insurance company duly converted from its previous form as a mutual insurance company in accordance with IC 27-15, and [insert names of parent company's executive officers, if applicable] as the [titles of executive officers], respectively, of [insert name of parent company], the parent company of [former mutual company], hereby certify as follows in accordance with 760 IAC 1-66-3.

1. [Institutional investor] organized under the laws of the State of _____, proposes to acquire beneficial ownership of 5% or more, but less than 10% of the shares of the [insert information on class of shares, [if any] shares of the voting securities of [former mutual or parent company], a former mutual insurance company [or parent company].

2. [Institutional investor] is not an "affiliate", as such term is defined in IC 27-1-23-1(b), of [former mutual company] or [parent company], and to the best of our knowledge, is acquiring the shares in the ordinary course of its business and is not acquiring those shares with the purpose or effect of changing or influencing the control, management, or policies of [former mutual company] or [any parent company]. The proposed purchase of shares would not cause or attempt to cause the substantial lessening of competition in any insurance market in the State of Indiana.

3. The boards of directors of [former mutual company] and [parent company] have approved such acquisition of shares by [institutional investor] or similar investors at meetings duly called and held on [date of meeting of former mutual company's board] and [date of meeting of parent company's board], respectively.

IN WITNESS WHEREOF, we have executed this Certificate this [date] of [month], [year].

_____
[Name], [Title]
[Name of former mutual]

_____
[Name], [Title]
[Name of former mutual]

_____
[Name], [Title]
[Name of parent company]

_____
[Name], [Title]
[Name of parent company]

(Department of Insurance; 760 IAC 1-66-6; filed Aug 3, 2001, 4:38 p.m.: 24 IR 3987)

760 IAC 1-66-7 Certificate of executive officers of institutional investor

Authority: IC 27-15-13-2
Affected: IC 27-1-23-1

Sec. 7. The certificate required under section 3 of this rule from the officers of an institutional investor shall be in the following form:

OFFICERS' CERTIFICATE
Regarding the Proposed Acquisition of Shares
of the Voting Securities of a Former Mutual

Insurance Company or Parent Company
Filed with the
INDIANA INSURANCE COMMISSIONER
By

_____
[Name of Institutional Investor]
An Institutional Investor under 760 IAC 1-66-2
organized in the State of _____, who proposed to
Acquire Beneficial Ownership of 5% or more,
but less than 10% of the Shares of
[Name of Former Mutual Company],
an Indiana former mutual insurance company
[insert name and description of parent
company, if applicable]
On its [their] Own Behalf
Name, title, address, and telephone number
of individuals to whom notices and correspondence
concerning this Certificate should be addressed:

_____
_____
_____
_____

Officers' Certificate

We, [names of two executive officers of institutional investor], as the [titles of executive officers], respectively, of [insert name of institutional investor], organized in the State of _____, hereby certify as follows in accordance with 760 IAC 1-66-3:

1. [Institutional investor] is an "institutional investor," as such term is defined in 760 IAC 1-66-2.

2. [Institutional investor] proposes to acquire beneficial ownership of 5% or more, but less than 10%, of the [insert information on class of shares, if any] shares of the voting securities of [former mutual or parent company whose shares are being acquired], an Indiana former mutual insurance company [or parent company].

3. [Institutional investor] will acquire such shares in the ordinary course of its business and not with the purpose or the effect of changing or influencing the control, management, or policies of [insert name of company whose shares are being acquired]. The proposed purchase of shares is solely for investment purposes and would not cause or attempt to cause the substantially lessening of competition in any insurance market in the State of Indiana.

4. [Institutional investor] is not an affiliate, as such term is defined in IC 27-1-23-1(b), of [former mutual company] or [parent company].

5. [Institutional investor] agrees to notify the Indiana Insurance Commissioner ("Commissioner"), [former mutual company] and [parent company] in writing not less than twenty (20) business days before any change in the matters herein certified, and comply with any actions required by the Commissioner as a result of such change.

6. [Institutional investor] understands that this Certificate is part of a filing, required by 760 IAC 1-66-3, that is deemed approved by the Commissioner upon receipt by the Commissioner. However, [institutional investor] also understands that the Commissioner may, in accordance with 760 IAC 1-66-4, prohibit [institutional investor] from purchasing, or require that [institutional investor] divest itself of, shares that represent five percent (5%) or more of the shares of [former mutual or parent company]. [Institutional investor] agrees to comply with any orders issued by the Commissioner under applicable law or regulation.

IN WITNESS WHEREOF, we have executed this Certificate this [date] of [month], [year].

_____
[Name], [Title]
[Name of institutional investor]

_____
[Name], [Title]

[Name of institutional investor]

(Department of Insurance; 760 IAC 1-66-7; filed Aug 3, 2001, 4:38 p.m.: 24 IR 3988)

Rule 67. Privacy of Consumer Information

760 IAC 1-67-1 Applicability and scope

Authority: IC 27-1-3-7; IC 27-2-20-3
Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 1. (a) This rule applies to nonpublic personal financial information about individuals who obtain or are claimants or beneficiaries of products or services primarily for personal, family, or household purposes from licensees of the department of insurance.

(b) This rule does not apply to information about companies or about individuals who:

(1) obtain products or services for business, commercial, or agricultural purposes; or

(2) are claiming benefits under a policy described in subsection (1).

(Department of Insurance; 760 IAC 1-67-1; filed Aug 31, 2001, 9:40 a.m.: 25 IR 85)

760 IAC 1-67-2 Definitions

Authority: IC 27-1-3-7; IC 27-2-20-3
Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5-5; IC 27-1-15.6; IC 27-1-15.8; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 2. The following definitions apply throughout this rule:

(1) "Affiliate" means any company that controls, is controlled by, or is under common control with another company.

(2) "Clear and conspicuous" means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice. The following are examples that meet this standard:

(A) A licensee makes its notice reasonably understandable if it does the following:

(i) Presents the information in the notice in clear, concise sentences, paragraphs, and sections.

(ii) Uses short explanatory sentences or bullet lists whenever possible.

(iii) Uses definite, concrete, everyday words and active voice whenever possible.

(iv) Avoids multiple negatives.

(v) Avoids legal and highly technical business terminology whenever possible.

(vi) Avoids explanations that are imprecise and readily subject to different interpretations.

(B) A licensee designs its notice to call attention to the nature and significance of the information in it if the licensee does the following:

(i) Uses a plain-language heading to call attention to the notice.

(ii) Uses a typeface and type size that are easy to read.

(iii) Provides wide margins and ample line spacing.

(iv) Uses boldface or italics for key words.

(v) In a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices, such as shading or sidebars.

(C) If a licensee provides a notice on a Web page, the licensee designs its notice to call attention to the nature and significance of the information in it if the licensee uses text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensure that other elements on the Web site, such as text, graphics, hyperlinks, or sound, do not distract attention from the notice, and the licensee does either of the following:

(i) Places the notice on a screen that consumers frequently access, such as a page on which transactions are conducted.

(ii) Places a link on a screen that consumers frequently access, such as a page on which transactions are

conducted, that connects directly to the notice and is labeled appropriately to convey the importance, nature, and relevance of the notice.

(3) "Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol, or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

(4) "Commissioner" means the commissioner of the Indiana department of insurance.

(5) "Company" means a corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship, or similar organization.

(6) "Consumer" means an individual who seeks to obtain, obtains, or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes, and about whom the licensee has nonpublic personal information, or that individual's legal representative, including the following:

(A) An individual provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment, or economic advisory services relating to an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship.

(B) An applicant for insurance prior to the inception of insurance coverage is a licensee's consumer.

(C) An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution.

(D) An individual is a licensee's consumer if the individual is:

(i) a beneficiary of a life insurance policy underwritten by the licensee;

(ii) a claimant under an insurance policy issued by the licensee;

(iii) an insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee; or

(iv) a mortgagor of a mortgage covered under a mortgage insurance policy;

and the licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party other than as permitted under sections 12 through 14 of this rule.

(E) Provided that the licensee provides the initial, annual, and revised notices under sections 3, 4, and 7 of this rule to the plan sponsor, group, or blanket insurance policyholder or group annuity contractholder, and further provided that the licensee does not disclose to a nonaffiliated third party nonpublic personal financial information about such an individual other than as permitted under sections 12 through 14 of this rule, an individual is not the consumer of the licensee solely because he or she is:

(i) a participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer, or fiduciary; or

(ii) covered under a group or blanket insurance policy or group annuity contract issued by the licensee.

(F) The individuals described in clause (E) are consumers of a licensee if the licensee does not meet all the conditions of this subdivision. In no event shall the individuals, solely by virtue of the status described in clause (E), be deemed to be customers.

(G) An individual is not a licensee's consumer solely because he or she is a beneficiary of a trust for which the licensee is a trustee.

(H) An individual is not a licensee's consumer solely because he or she has designated the licensee as trustee for a trust.

(7) "Consumer reporting agency" has the same meaning as Section 603(f) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(f)).

(8) "Control" means any of the following:

(A) Ownership, control, or power to vote twenty-five percent (25%) or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one (1) or more other persons.

(B) Control in any manner over the election of a majority of the directors, trustees, or general partners (or individuals exercising similar functions) of the company.

(C) The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the commissioner determines.

(9) "Customer" means a consumer who has a customer relationship with a licensee. A beneficiary or a claimant shall not be deemed a customer solely by virtue of his or her status as a beneficiary or a claimant.

(10) "Customer relationship" means a continuing relationship between a consumer and a licensee under which the licensee

provides one (1) or more insurance products or services to the consumer that are to be used primarily for personal, family, or household purposes, including the following:

(A) A consumer has a continuing relationship with a licensee if the consumer:

(i) is a current policyholder of an insurance product issued by or through the licensee; or

(ii) obtains financial, investment, or economic advisory services relating to an insurance product or service from the licensee for a fee.

(B) A consumer does not have a continuing relationship with a licensee in any of the following circumstances:

(i) The consumer applies for insurance but does not purchase the insurance.

(ii) The licensee sells the consumer airline travel insurance in an isolated transaction.

(iii) The individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee.

(iv) The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee.

(v) The consumer is a beneficiary or a claimant under a policy and has submitted a claim under that policy choosing a lump sum settlement option.

(vi) The customer's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve (12) consecutive months, other than annual privacy notices, material required by law or rule, communication at the direction of a state or federal authority, or promotional materials.

(vii) The individual is an insured or an annuitant under an insurance policy or annuity, respectively, but is not the policyholder or owner of the insurance policy or annuity.

(viii) For purposes of this rule, the individual's last known address, according to the licensee's records, is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(11) "Financial institution" means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in Section 4(k) of the Bank Holding Company Act of 1956, 12 U.S.C. 1843(k). The term does not include any of the following:

(A) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act, 7 U.S.C. 1 et seq.

(B) The Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971, 12 U.S.C. 2001 et seq.

(C) Institutions chartered by Congress specifically to engage in securitizations, secondary market sales (including sales of servicing rights), or similar transactions related to a transaction of a consumer, as long as the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

(12) "Financial product or service" means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under Section 4(k) of the Bank Holding Company Act of 1956, 12 U.S.C. 1843(k). Financial service includes a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service.

(13) "Health information" means any information or data, except age or gender, whether oral or recorded in any form or medium, created by or derived from a health care provider or the consumer that relates to any of the following:

(A) The past, present, or future physical, mental, or behavioral health or condition of an individual.

(B) The provision of health care to an individual.

(C) Payment for the provision of health care to an individual.

(14) "Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of this state. Insurance service includes a licensee's evaluation, brokerage, or distribution of information that the licensee collects in connection with a request or an application from a consumer for an insurance product or service.

(15) "Licensee" means all licensed insurers, health maintenance organizations, agents, producers, and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered under IC 27.

The following requirements apply:

(A) A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information set forth in section 1 of this rule, this section, and sections 3 through 15 of this rule if the licensee is an employee, agent, or other representative of another licensee and:

(i) the other licensee otherwise complies with, and provides the notices required by this rule; and

(ii) the licensee does not disclose any nonpublic personal information to any person other than the principal or its affiliates in a manner permitted by this rule.

(B) A licensee also includes an unauthorized insurer that accepts business placed through a licensed surplus lines broker in this state, but only in regard to the surplus lines placements placed pursuant to IC 27-1-15.5-5. A surplus lines broker or surplus lines insurer shall be deemed to be in compliance with the notice and opt out requirements for nonpublic personal financial information set forth in section 1 of this rule, this section, and sections 3 through 15 of this rule provided the following:

(i) The surplus lines agent or insurer does not disclose nonpublic personal information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing under section 12 of this rule, except as permitted by section 13 or 14 of this rule.

(ii) The surplus lines agent or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in 16-point type:

PRIVACY NOTICE

NEITHER THE U.S. SURPLUS LINES AGENTS THAT HANDLED THIS INSURANCE NOR THE INSURERS THAT HAVE UNDERWRITTEN THIS INSURANCE WILL DISCLOSE NONPUBLIC PERSONAL INFORMATION CONCERNING THE BUYER TO NONAFFILIATES OF THE BROKERS OR INSURERS EXCEPT AS PERMITTED BY LAW.

(16) "Nonaffiliated third party" means any person except a licensee's affiliate or a person employed jointly by a licensee and any company that is not the licensee's affiliate. The term includes either of the following:

(A) The other company that jointly employs the person.

(B) Any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities or insurance company investment activities of the type described in the federal Bank Holding Company Act, 12 U.S.C. 1843(k)(4)(H) and 12 U.S.C. 1843(k)(4)(I).

(17) "Nonpublic personal financial information" means personally identifiable financial information and any list, description, or other grouping of consumers (and publicly available information pertaining to them) that is derived using any personally identifiable financial information that is not publicly available, including the following:

(A) The term includes any list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information that is not publicly available, such as account numbers.

(B) The term does not include any of the following:

(i) Health information.

(ii) Publicly available information, except as included on a list described in subdivision (21).

(iii) Any list, description, or other grouping of consumers (and publicly available information pertaining to them) that is derived without using any personally identifiable financial information that is not publicly available.

(C) The term does not include any list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution.

(18) "Nonpublic personal information" means nonpublic personal financial information.

(19) "Personally identifiable financial information" means information a consumer provides to a licensee to obtain an insurance product or service from the licensee, information about a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer, or information the licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer, including the following:

(A) The term includes the following:

(i) Information a consumer provides to a licensee on an application to obtain an insurance product or service.

(ii) Account balance information and payment history.

(iii) The fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee.

(iv) Any information about the licensee's consumer if it is disclosed in a manner that indicates that the individual is or has been the licensee's consumer.

(v) Any information that a consumer provides to a licensee or that the licensee or its agent otherwise obtains in connection with collecting on a loan or servicing a loan.

(vi) Any information the licensee collects through an Internet cookie (an information-collecting device from a Web server).

(vii) Information from a consumer report.

(B) The term does not include the following:

(i) Health information.

(ii) A list of names and addresses of customers of an entity that is not a financial institution.

(iii) Information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers, such as account numbers, names, or addresses.

(20) "Producer" means a person licensed under IC 27-1-15.5, IC 27-1-15.6, or IC 27-1-15.8.

(21) "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state, or local government records, widely distributed media, or disclosures to the general public that are required to be made by federal, state, or local law. The following requirements apply:

(A) A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine that the information is of the type that is available to the general public and whether an individual can direct that the information not be made available to the general public, and, if so, that the licensee's consumer has not done so.

(B) Publicly available information in government records includes information in government real estate records and security interest filings.

(C) Publicly available information from widely distributed media includes information from a:

(i) telephone book;

(ii) television;

(iii) radio program;

(iv) newspaper; or

(v) Web site;

that is available to the general public on an unrestricted basis. A Web site is not restricted merely because an Internet service provider or a site operator requires a fee or a password, so long as access is available to the general public.

(D) A licensee has a reasonable basis to believe that mortgage information is lawfully made available to the general public if the licensee has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded.

(E) A licensee has a reasonable basis to believe that an individual's telephone number is lawfully made available to the general public if the licensee has located the telephone number in the telephone book or the consumer has informed you that the telephone number is not unlisted.

(Department of Insurance; 760 IAC 1-67-2; filed Aug 31, 2001, 9:40 a.m.: 25 IR 85)

760 IAC 1-67-3 Initial privacy notice to consumers

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13

Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 3. (a) A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to the following:

(1) An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship,

except as provided in subsection (e).

(2) A consumer, before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by sections 13 and 14 of this rule.

(b) A licensee is not required to provide an initial notice to a consumer under subsection (a) in either of the following instances:

(1) The licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by sections 13 and 14 of this rule, and the licensee does not have a customer relationship with the consumer.

(2) A notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

(c) A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship. The following are examples of establishing customer relationship:

(1) The consumer becomes a policyholder of a licensee that is an insurer when the insurer delivers an insurance policy or contract to the consumer, or in the case of a licensee that is an insurance producer or insurance agent, obtains insurance through that licensee.

(2) The consumer agrees to obtain financial, economic, or investment advisory services relating to insurance products or services for a fee from the licensee.

(d) When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes, the licensee satisfies the initial notice requirements of subsection (a) if:

(1) the licensee may provide a revised policy notice, under section 7 of this rule, that covers the customer's new insurance product or service; or

(2) the initial, revised, or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under subsection (a).

(e) The following are exceptions that allow subsequent delivery of the required notice:

(1) A licensee may provide the initial notice required by subsection (a)(1) within a reasonable time after the licensee establishes a customer relationship if:

(A) establishing the customer relationship is not at the customer's election; or

(B) providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

(2) The following are examples of exceptions:

(A) Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

(B) Providing notice not later than when a licensee establishes a customer relationship would substantially delay the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service.

(C) Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a Web site.

(f) When a licensee is required to deliver an initial privacy notice by this section, the licensee shall deliver it according to section 8 of this rule. If the licensee uses a short-form initial notice for noncustomers according to section 5(d) of this rule, the licensee may deliver its privacy notice according to section 5(d)(3) of this rule. *(Department of Insurance; 760 IAC 1-67-3; filed Aug 31, 2001, 9:40 a.m.: 25 IR 89)*

760 IAC 1-67-4 Annual privacy notice to customers

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13

Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 4. (a) A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship.

(1) As used in this section, "annually" means at least once in any period of twelve (12) consecutive months during which that relationship exists. A licensee may define the twelve (12) consecutive month period, but the licensee shall apply it to the customer on a consistent basis.

(2) A licensee provides a notice annually if it defines the twelve (12) consecutive month period as a calendar year and provides the annual notice to the customer once in each calendar year following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of Year 1, the licensee shall provide an annual notice to that customer by December 31 of Year 2.

(b) A licensee is not required to provide an annual notice to a former customer. As used in this section, "former customer" means an individual with whom a licensee no longer has a continuing relationship and includes the following:

(1) The individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee.

(2) The individual's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve (12) consecutive months, other than to provide annual privacy notices, material required by law or rule, or promotional materials.

(3) An individual if the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(4) In the case of providing real estate settlement services, at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

(c) When a licensee is required by this section to deliver an annual privacy notice, the licensee shall deliver it according to section 8 of this rule. *(Department of Insurance; 760 IAC 1-67-4; filed Aug 31, 2001, 9:40 a.m.: 25 IR 90)*

760 IAC 1-67-5 Information to be included in privacy notices

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13

Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 5. (a) The initial, annual, and revised privacy notices that a licensee provides under sections 3, 4, and 7 of this rule shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

(1) The categories of nonpublic personal financial information that the licensee collects.

(2) The categories of nonpublic personal financial information that the licensee discloses.

(3) The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under sections 13 and 14 of this rule.

(4) The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under sections 13 and 14 of this rule.

(5) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under section 12 of this rule (and no other exception in sections 13 and 14 of this rule applies to that disclosure), a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted.

(6) An explanation of the consumer's right under section 9(a) of this rule to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time.

(7) Any disclosures that the licensee makes under Section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act, 15 U.S.C. 1681a(d)(2)(A)(iii), regarding the ability to opt out of disclosures of information among affiliates.

(8) The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

(9) Any disclosure that the licensee makes under subsection (b).

(b) If a licensee discloses nonpublic personal financial information as authorized under sections 13 and 14 of this rule, the licensee is not required to list those exceptions in the initial or annual privacy notices required by sections 3 and 4 of this rule. When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

(c) The following are examples:

(1) A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable information:

(A) from the consumer;

(B) about the consumer's transactions with the licensee or its affiliates;

(C) about the consumer's transactions with nonaffiliated third parties; and

(D) from a consumer reporting agency.

(2) A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in subdivision (1), as applicable, and provides a few examples to illustrate the types of information in each category. These examples might include the following:

(A) Information from the consumer, including application information, such as assets and income and identifying information, such as name, address, and Social Security number.

(B) Transaction information, such as information about balances, payment history, and parties to the transaction.

(C) Information from consumer reports, such as a consumer's creditworthiness and credit history.

(3) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer. If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information that the licensee discloses.

(4) A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which they engage.

(A) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking, or securities brokerage.

(B) A licensee also may categorize the affiliates and nonaffiliated third parties to which it discloses nonpublic personal financial information about consumers using more detailed categories.

(5) If a licensee discloses nonpublic personal financial information under the exception contained in section 12 of this rule to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of subsection (a)(5) if it:

(A) lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of subsection (a)(2), as applicable; and

(B) states whether the third party is a:

(i) service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(ii) financial institution with whom the licensee has a joint marketing agreement.

(6) If a licensee does not disclose, and does not wish to reserve the right to disclose, nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties, except as authorized under sections 13 and 14 of this rule, the licensee may simply state that fact, in addition to the information it shall provide under subsections (a)(1), (a)(8), (a)(9), and (b).

(7) A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following:

(A) Describes in general terms who is authorized to have access to the information.

(B) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

(d) A licensee may satisfy the initial notice requirements of sections 3(a)(2) and 6(c) of this rule for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers an opt out notice as required in section 6 of this rule.

(1) A short-form notice shall:

(A) be clear and conspicuous;

(B) state that the licensee's privacy notice is available upon request; and

(C) explain a reasonable means by which the consumer may obtain that notice.

(2) The licensee shall deliver its short-form initial notice according to section 8 of this rule. The licensee is not required to deliver its privacy notice with its short-form initial notice. The licensee instead may provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to section 8 of this rule.

(3) The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee does either of the following:

(A) Provides a toll free telephone number that the consumer may call to request the notice.

(B) For a consumer who conducts business in person at the licensee's office, maintains copies of the notice on hand that the licensee provides to the consumer immediately upon request.

(e) The licensee's notice may include the following:

(1) Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but does not currently disclose.

(2) Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the license does not currently disclose, nonpublic financial information.

(f) Sample clauses illustrating some of the notice content required by this section are included in section 17 of this rule. *(Department of Insurance; 760 IAC 1-67-5; filed Aug 31, 2001, 9:40 a.m.: 25 IR 90)*

760 IAC 1-67-6 Form of opt out notice to consumers and opt out methods

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13

Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 6. (a) If a licensee is required to provide an opt out notice under section 10(a) of this rule, it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under that section.

(1) The notice shall state all of the following:

(A) The licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party.

(B) The consumer has the right to opt out of that disclosure.

(C) A reasonable means by which the consumer may exercise the opt out right.

(2) The following are examples:

(A) A licensee provides adequate notice that the consumer can opt out of the disclosure of nonpublic personal financial information to a nonaffiliated third party if the licensee does all of the following:

(i) Identifies all of the categories of nonpublic personal financial information that it discloses or reserves the right to disclose, and all of the categories of nonaffiliated third parties to which the licensee discloses the information, as described in section 5(a)(2) and 5(a)(3) of this rule.

(ii) States that the consumer can opt out of the disclosure of that information.

(iii) Identifies the insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the opt out direction would apply.

(B) A licensee provides a reasonable means to exercise an opt out right if it does any of the following:

(i) Designates check-off boxes in a prominent position on the relevant forms with the opt out notice.

(ii) Includes a reply form together with the opt out notice.

(iii) Provides an electronic means to opt out, such as a form that can be sent via electronic mail or a process at the licensee's Web site, if the consumer agrees to the electronic delivery of information.

(iv) Provides a toll free telephone number that consumers may call to opt out.

(C) A licensee does not provide a reasonable means of opting out if the only means of opting out:

(i) is for the consumer to write his or her own letter to exercise that opt out right; or

(ii) as described in any notice subsequent to the initial notice, is to use a check-off box that the licensee provided with the initial notice, but did not include with the subsequent notice.

(D) A licensee may require each consumer to opt out through a specific means as long as that means is reasonable for that consumer.

(b) A licensee may provide the opt out notice together with or on the same written or electronic form as the initial notice the licensee provides in accordance with section 3 of this rule.

(c) If a licensee provides the opt out notice later than required for the initial notice in accordance with section 3 of this rule, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

(d) The following apply to joint relationships:

(1) If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice. The licensee's opt out notice shall explain how the licensee will treat an opt out direction by a joint consumer.

(2) Any of the joint consumers may exercise the right to opt out. The licensee may either:

(A) treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

(B) permit each joint consumer to opt out separately.

(3) If a licensee permits each joint consumer to opt out separately, the licensee shall permit one (1) of the joint consumers to opt out on behalf of all of the joint consumers.

(4) A licensee may not require all joint consumers to opt out before it implements any opt out direction.

(5) The following example is illustrative. If John and Mary are both named policyholders on a homeowner's insurance policy issued by a licensee and the licensee sends policy statements to John's address, the licensee may do any of the following, but it shall explain in its opt out notice which opt out policy the licensee will follow:

(A) Send a single opt out notice to John's address, but the licensee shall accept an opt out direction from either John or Mary.

(B) Treat an opt out direction by either John or Mary as applying to the entire policy. If the licensee does so and John opts out, the licensee may not require Mary to opt out as well before implementing John's opt out direction.

(C) Permit John and Mary to make different opt out directions. If the licensee does so:

(i) it shall permit John and Mary to opt out for each other;

(ii) if both opt out, the licensee shall permit both of them to notify it in a single response; and

(iii) if John opts out and Mary does not, the licensee may only disclose nonpublic personal financial information about Mary, but not about John and not about John and Mary jointly.

(e) A licensee shall comply with the consumer's opt out direction as soon as reasonably practicable after it is received by the licensee.

(f) A consumer may exercise the right to opt out at any time.

(g) A consumer's direction to opt out under this section is effective until the consumer revokes it in writing or, if the consumer agrees, electronically. When a consumer relationship terminates, the customer's opt out direction continues to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.

(h) When a licensee is required to deliver an opt out notice by this section, the licensee shall deliver it according to section 8 of this rule. *(Department of Insurance; 760 IAC 1-67-6; filed Aug 31, 2001, 9:40 a.m.: 25 IR 92)*

760 IAC 1-67-7 Revised privacy notices

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13

Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 7. (a) Except as otherwise authorized in this rule, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice that the licensee provided to that consumer under section 3 of this rule unless the:

(1) licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

(2) licensee has provided to the consumer a new opt out notice;

(3) licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(4) consumer does not opt out.

(b) Except as otherwise permitted by sections 12 through 14 of this rule, a licensee shall provide a revised notice before it does any of the following:

(1) Discloses a new category of nonpublic personal financial information to any nonaffiliated third party.

(2) Discloses nonpublic personal financial information to a new category of nonaffiliated third party.

(3) Discloses nonpublic personal financial information about a former customer to a nonaffiliated third party, if that former customer has not had the opportunity to exercise an opt out right regarding that disclosure.

(c) A revised notice is not required if the licensee discloses nonpublic personal financial information to a new nonaffiliated third party that the licensee adequately described in its prior notice.

(d) When a licensee is required to deliver a revised privacy notice by this section, the licensee shall deliver it according to section 8 of this rule. *(Department of Insurance; 760 IAC 1-67-7; filed Aug 31, 2001, 9:40 a.m.: 25 IR 93)*

760 IAC 1-67-8 Delivery

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13

Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 8. (a) A licensee shall provide any notices that this rule requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

(b) A licensee may reasonably expect that a consumer will receive actual notice if the licensee does any of the following:

(1) Hand delivers a printed copy of the notice to the consumer.

(2) Mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing, or other written communication.

(3) For a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service.

(4) For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

(c) A licensee may not reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it does either of the following:

(1) Only posts a sign in its office or generally publishes advertisements of its privacy policies and practices.

(2) Sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

(d) A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if the customer:

(1) uses the licensee's Web site to access insurance products and services electronically and agrees to receive notices at the Web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the Web site; or

(2) has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

(e) A licensee may not provide any notice required by this rule solely by orally explaining the notice, either in person or over the telephone.

(f) For customers only, a licensee shall provide the initial notice required by section 3(a)(1) of this rule, the annual notice required by section 4(a) of this rule, and the revised notice required by section 7 of this rule so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically. A licensee provides a privacy notice to the customer so that the customer can retain it or obtain it later if the licensee does any of the following:

(1) Hand delivers a printed copy of the notice to the customer.

(2) Mails a printed copy of the notice to the last known address of the customer.

(3) Makes its current privacy notice available on a Web site (or a link to another Web site) for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the Web site.

(g) A licensee may provide a joint notice from the licensee and one (1) or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee also may provide a notice on behalf of another financial institution.

(h) If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual, and revised notice requirements of sections 3(a), 4(a), and 7(a) of this rule, by providing one (1) notice to those consumers jointly. *(Department of Insurance; 760 IAC 1-67-8; filed Aug 31, 2001, 9:40 a.m.: 25 IR 93)*

760 IAC 1-67-9 Limits on disclosure of nonpublic personal financial information to nonaffiliated third parties

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13

Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 9. (a) Except as otherwise authorized in this rule, a licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless the:

(1) licensee has provided to the consumer an initial notice as required under section 3 of this rule;

(2) licensee has provided to the consumer an opt out notice as required in section 6 of this rule;

(3) licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(4) consumer does not opt out.

(b) Opt out means a direction by the consumer that the licensee not disclose nonpublic personal financial information about that consumer to a nonaffiliated third party, other than as permitted by sections 12 through 14 of this rule.

(c) A licensee provides a consumer with a reasonable opportunity to opt out if the licensee does any of the following:

(1) The licensee mails the notices required in subsection (a) to the consumer and allows the consumer to opt out by mailing a form, calling a toll free telephone number or any other reasonable means within thirty (30) days from the date the licensee mailed the notices.

(2) A customer opens an on-line account with a licensee and agrees to receive the notices required in subsection (a) electronically, and the licensee allows the customer to opt out by any reasonable means within thirty (30) days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account.

(3) For an isolated transaction, such as providing the consumer with an insurance quote, a licensee provides the consumer with a reasonable opportunity to opt out if the licensee provides the notices required in subsection (a) at the time of the transaction and requests that the consumer decide, as a necessary part of the transaction, whether to opt out before completing the transaction.

(d) A licensee shall comply with this section, regardless of whether the licensee and the consumer have established a customer relationship. Unless a licensee complies with this section, the licensee may not, directly or through any affiliate, disclose any

nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving the direction to opt out from the consumer.

(e) A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out. *(Department of Insurance; 760 IAC 1-67-9; filed Aug 31, 2001, 9:40 a.m.: 25 IR 94)*

760 IAC 1-67-10 Limits on redisclosure and reuse of nonpublic personal financial information

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13

Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 10. (a) If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in section 13 or 14 of this rule, the licensee's disclosure and use of that information is limited as follows:

(1) The licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information.

(2) The licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information.

(3) The licensee may disclose and use the information pursuant to an exception in section 13 or 14 of this rule, in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

For example, if a licensee receives information from a nonaffiliated financial institution for claims settlement purposes, the licensee may disclose the information for fraud prevention, or in response to a properly authorized subpoena. The licensee may not disclose that information to a third party for marketing purposes or use that information for its own marketing purposes.

(b) If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in section 13 or 14 of this rule, the licensee may disclose the information only to:

(1) the affiliates of the financial institution from which the licensee received the information;

(2) its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

(3) any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information.

For example, if a licensee obtains a customer list from a nonaffiliated financial institution outside of the exceptions in section 13 or 14 of this rule, the licensee may use that list for its own purposes, and the licensee may disclose that list to another nonaffiliated third party only if the financial institution from which the licensee purchased the list could have lawfully disclosed the list to that third party. That is, the licensee may disclose the list in accordance with the privacy policy of the financial institution from which the licensee received the list, as limited by the opt out direction of each consumer whose nonpublic personal financial information the licensee intends to disclose, and the licensee may disclose the list in accordance with an exception in section 13 or 14 of this rule, such as to the licensee's attorneys or accountants.

(c) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in section 13 or 14 of this rule, the third party may disclose and use that information only as follows:

(1) The third party may disclose the information to the licensee's affiliates.

(2) The third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information.

(3) The third party may disclose and use the information pursuant to an exception in section 13 or 14 of this rule in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

(d) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in section 13 or 14 of this rule, the third party may disclose the information only to:

(1) the licensee's affiliates;

(2) the third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

(3) any other person, if the disclosure would be lawful if the licensee made it directly to that person.

(Department of Insurance; 760 IAC 1-67-10; filed Aug 31, 2001, 9:40 a.m.: 25 IR 95)

760 IAC 1-67-11 Limits on sharing account number information for marketing purposes

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13

Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 11. (a) A licensee shall not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail to the consumer.

(b) Subsection (a) does not apply if a licensee discloses a policy number or similar form of access number or access code to any of the following:

(1) The licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account.

(2) A licensee who is a producer solely in order to perform marketing for the licensee's own products or services.

(3) A participant in an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program.

(c) A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the licensee does not provide the recipient with a means to decode the number or code.

(d) For purposes of this section, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges. *(Department of Insurance; 760 IAC 1-67-11; filed Aug 31, 2001, 9:40 a.m.: 25 IR 96)*

760 IAC 1-67-12 Exception to opt out requirements for disclosure of nonpublic personal financial information for service providers and joint marketing

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13

Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 12. (a) The opt out requirements in sections 6 and 9 of this rule do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee:

(1) provides the initial notice in accordance with section 3 of this rule; and

(2) enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in section 13 or 14 of this rule in the ordinary course of business to carry out those purposes.

For example, if a licensee discloses nonpublic personal financial information under this section to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that institution meets the requirements of this subsection if it prohibits the institution from disclosing or using the nonpublic personal financial information, except as necessary to carry out the joint marketing or under an exception in section 13 or 14 of this rule in the ordinary course of business to carry out that joint marketing.

(b) The services a nonaffiliated third party performs for a licensee under subsection (a) may include marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one (1) or more financial institutions.

(c) As used in this section, "joint agreement" means a written contract pursuant to which a licensee and one (1) or more financial institutions jointly offer, endorse, or sponsor a financial product or service. *(Department of Insurance; 760 IAC 1-67-12; filed Aug 31, 2001, 9:40 a.m.: 25 IR 96)*

760 IAC 1-67-13 Exceptions to notice and opt out requirements for disclosure of nonpublic personal financial information for processing and servicing transactions

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13

Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 13. (a) The requirements for initial notice in section 3(a)(2) of this rule, the opt out in sections 6 and 9 of this rule, and service providers and joint marketing in section 12 of this rule do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer, or enforce a transaction that a consumer requests or authorizes, or in connection with any of the following:

(1) Servicing or processing an insurance product or service that a consumer requests or authorizes.

(2) Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity.

(3) A proposed or actual securitization, secondary market sale, including sales of servicing rights, or similar transaction related to a transaction of the consumer.

(4) Reinsurance or stop loss or excess loss insurance.

(5) To provide information to the policyholder or the producer who procured the insurance policy with respect to a claim under the insurance policy.

(b) As used in this section, "necessary to effect, administer, or enforce a transaction" means that the disclosure is required, or is either of the following:

(1) One (1) of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service.

(2) A usual, appropriate, or acceptable method to do the following:

(A) Carry out the transaction or the product or service business of which the transaction is a part, and record, service, or maintain the consumer's account in the ordinary course of providing the insurance product or service.

(B) Administer or service benefits or claims relating to the transaction or the product or service business of which it is a part.

(C) Provide a confirmation, statement, or other record of the transaction, or information on the status or value of the insurance product or service to the consumer or the consumer's agent or broker.

(D) Accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party.

(E) Underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer's insurance:

(i) Account administration.

(ii) Reporting.

(iii) Investigating or preventing fraud or material misrepresentation.

(iv) Processing premium payments.

(v) Processing insurance claims.

(vi) Administering insurance benefits, including utilization review activities.

(vii) Participating in research projects.

(viii) As otherwise required or specifically permitted by federal or state law.

(ix) In connection with any of the following:

(AA) Authorization, settlement, billing, processing, clearing, transferring, reconciling, or collection of amounts charged, debited, or otherwise paid using a debit, credit, or other payment card, check, or account number, or by other payment means.

(BB) Transfer of receivables, accounts, or interests therein.

(CC) Audit of debit, credit, or other payment information.

(Department of Insurance; 760 IAC 1-67-13; filed Aug 31, 2001, 9:40 a.m.: 25 IR 97)

760 IAC 1-67-14 Other exceptions to notice and opt out requirements for disclosure of nonpublic personal financial information

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13

Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 14. (a) The requirements for initial notice to consumers in section 3(a)(2) of this rule, the opt out in sections 6 and 9 of this rule, and service providers and joint marketing in section 12 of this rule do not apply when a licensee discloses nonpublic personal financial information as follows:

(1) With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction.

(2) In any of the following situations:

(A) To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product, or transaction.

(B) To protect against or prevent actual or potential fraud or unauthorized transactions.

(C) For required institutional risk control or for resolving consumer disputes or inquiries.

(D) To persons holding a legal or beneficial interest relating to the consumer.

(E) To persons acting in a fiduciary or representative capacity on behalf of the consumer.

(3) To provide information to the following:

(A) Insurance rate advisory organizations.

(B) Guaranty funds or agencies.

(C) Agencies that are rating a licensee.

(D) Persons who are assessing the licensee's compliance with industry standards.

(E) The licensee's attorneys, accountants, and auditors.

(4) To the extent specifically permitted or required under other provisions of law and in accordance with the federal Right to Privacy Act of 1978 (12 U.S.C. 3401 et seq.), to law enforcement agencies, including the Federal Reserve Board, Office of the Comptroller of the Currency, Federal Deposit Insurance Corporation, Office of Thrift Supervision, National Credit Union Administration, the Securities and Exchange Commission, the Secretary of the Treasury, with respect to 31 U.S.C. Chapter 53, Subchapter II (Records and Reports on Monetary Instruments and Transactions) and 12 U.S.C. Chapter 21 (Financial Recordkeeping), a state insurance authority, and the Federal Trade Commission, self-regulatory organization or for an investigation on a matter related to public safety.

(5) To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.) or from a consumer report reported by a consumer reporting agency.

(6) In connection with a proposed or actual sale, merger, transfer, or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit.

(7) To comply with or respond to any of the following:

(A) Federal, state, or local laws, rules, and other applicable legal requirements.

(B) Properly authorized civil, criminal, or regulatory investigation, or subpoena, or summons by federal, state, or local authorities.

(C) Judicial process or governmental regulatory authorities having jurisdiction over a licensee for examination, compliance, or other purposes as authorized by law.

(8) For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan, or a workers' compensation plan.

(b) A consumer may revoke consent by subsequently exercising the right to opt out of future disclosures of nonpublic personal information as permitted under section 6(f) of this rule. *(Department of Insurance; 760 IAC 1-67-14; filed Aug 31, 2001, 9:40 a.m.: 25 IR 97)*

760 IAC 1-67-15 Protection of Fair Credit Reporting Act

Authority: IC 27-1-3-7; IC 27-2-20-3
Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 15. Nothing in this rule shall be construed to modify, limit, or supersede the operation of the federal Fair Credit Reporting Act, 15 U.S.C. 1681 et seq., and no inference shall be drawn on the basis of the provisions of this rule regarding whether information is transaction or experience information under Section 603 of the Fair Credit Reporting Act. *(Department of Insurance; 760 IAC 1-67-15; filed Aug 31, 2001, 9:40 a.m.: 25 IR 98)*

760 IAC 1-67-16 Nondiscrimination

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13
Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 16. A licensee shall not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of his or her nonpublic personal financial information. *(Department of Insurance; 760 IAC 1-67-16; filed Aug 31, 2001, 9:40 a.m.: 25 IR 98)*

760 IAC 1-67-17 Sample clauses

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13
Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 17. (a) A licensee may use the following statement, as applicable, to meet the requirements of section 5(a)(1) of this rule, to describe the categories of nonpublic personal information the licensee collects, "We collect nonpublic personal information about you from the following sources:

(1) Information we receive from you on applications or other forms.

(2) Information about your transactions with us, our affiliates, or others.

(3) Information we receive from a consumer reporting agency.".

(b) A licensee may use one (1) of the statements in this subsection, as applicable, to meet the requirement of section 5(a)(2) of this rule, to describe the categories of nonpublic personal information the licensee discloses. The licensee may use either of the following statements if it discloses nonpublic personal information other than as permitted by the exceptions in sections 12 through 14 of this rule:

(1) "We may disclose the following kinds of nonpublic personal information about you:

(A) Information we receive from you on applications or other forms, such as (provide illustrative examples, such as 'your name, address, Social Security number, assets, income, and beneficiaries').

(B) Information about your transactions with us, our affiliates, or others, such as (provide illustrative example, such as 'your policy coverage, premiums, and payment history').

(C) Information we receive from a consumer reporting agency, such as (provide illustrative examples, such as 'your creditworthiness and credit history').".

(2) "We may disclose all of the information that we collect, as described (describe location in the notice, such as 'above' or 'below').".

(c) A licensee may use the statement is this subsection, as applicable, to meet the requirements of section 5(a)(2), 5(a)(3), and 5(a)(4) of this rule, to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses. A licensee may use the following statement if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in sections 13 and 14 of this rule, "We do not disclose any nonpublic personal information about our customers or former

customers to anyone, except as permitted by law.".

(d) A licensee may use the statement in this subsection, as applicable, to meet the requirement of section 5(a)(3) of this rule, to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information. The following statement may be used if the licensee discloses nonpublic personal information other than as permitted by the exceptions in sections 12 through 14 of this rule, as well as when permitted by the exceptions in sections 13 and 14 of this rule, "We may disclose nonpublic personal information about you to the following types of third parties:

(1) Financial service providers, such as (provide illustrative examples, such as 'life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents').

(2) Nonfinancial companies, such as (provide illustrative examples, such as 'retailers, direct marketers, airlines, and publishers').

(3) Others, such as (provide illustrative examples, such as 'nonprofit organizations').

We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.".

(e) A licensee may use one (1) of the statements in this subsection, as applicable, to meet the requirements of section 5(a)(5) of this rule, related to the exception for service providers and joint marketers in section 12 of this rule. The licensee may use either of the following statements, if a licensee discloses nonpublic personal information under the exception in section 12 of this rule, the licensee shall describe the categories of nonpublic personal information the licensee discloses and the categories of third parties with which the licensee has contracted:

(1) "We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements:

(A) Information we receive from you on applications or other forms, such as (provide illustrative examples, such as 'your name, address, Social Security number, assets, income, and beneficiaries').

(B) Information about your transactions with us, our affiliates or others, such as (provide illustrative examples, such as 'your policy coverage, premium, and payment history').

(C) Information we receive from a consumer reporting agency, such as (provide illustrative examples, such as 'your creditworthiness and credit history').".

(2) "We may disclose all of the information we collect, as described (describe location in the notice, such as 'above' or 'below') to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.".

(f) A licensee may use the statement in this subsection, as applicable, to meet the requirement of section 5(a)(6) of this rule, to provide an explanation of the consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the method or methods by which the consumer may exercise that right. The licensee may use the followings statement if the licensee discloses nonpublic personal information other than as permitted by the exceptions in sections 12 through 14 of this rule, "If you prefer that we do not disclose nonpublic personal financial information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures required by law). If you wish to opt out of disclosures to third parties, you may (describe reasonable means of opting out, such as 'call the following toll free number: (insert number)').".

(g) A licensee may use the following statement, as applicable, to meet the requirement of section 5(a)(8) of this rule to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information, "We restrict access to nonpublic personal information about you to (provide an appropriate description, such as 'those employees who need to know that information to provide products or services to you'). We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.". *(Department of Insurance; 760 IAC 1-67-17; filed Aug 31, 2001, 9:40 a.m.: 25 IR 98)*

760 IAC 1-67-18 Violation

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13

Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-4-1; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 18. A violation of this rule is deemed an unfair method of competition and an unfair and deceptive act and practice in

the business of insurance subject to the provisions of IC 27-4-1. *(Department of Insurance; 760 IAC 1-67-18; filed Aug 31, 2001, 9:40 a.m.: 25 IR 100)*

760 IAC 1-67-19 Severability

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13
Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 19. If any section or portion of a section of this rule or its applicability to any person or circumstance is held invalid by a court, the remainder of the rule or the applicability of the provision to other persons or circumstances shall not be affected. *(Department of Insurance; 760 IAC 1-67-19; filed Aug 31, 2001, 9:40 a.m.: 25 IR 100)*

760 IAC 1-67-20 Effective date

Authority: IC 27-1-3-7; IC 27-1-15.5-16; IC 27-1-25-14; IC 27-1-33-11; IC 27-2-20-3; IC 27-8-16-14; IC 27-8-17-20; IC 27-8-19.8-26; IC 27-13-10-13
Affected: IC 27-1-7-2; IC 27-1-12-1; IC 27-1-13-1; IC 27-1-15.5; IC 27-1-17-2; IC 27-1-23; IC 27-1-25; IC 27-1-33; IC 27-6-6; IC 27-6-9; IC 27-7-3; IC 27-8-1; IC 27-8-16; IC 27-8-17; IC 27-8-19.8; IC 27-10-3; IC 27-13

Sec. 20. (a) This rule is effective thirty (30) days after filing with the secretary of state's office. In order provide sufficient time for licensees to establish policies and systems to comply with the requirements of this rule, the commissioner has extended the time for compliance with this rule until July 1, 2001.

(b) By July 1, 2001, a licensee shall provide an initial notice, as required by section 3 of this rule, to consumers who are the licensee's customers on July 1, 2001.

(c) Until July 1, 2002, a contract that a licensee has entered into with a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf satisfies the provision of section 12(a) of this rule, even if the contract does not include a requirement that the third party maintain the confidentiality of nonpublic personal information, as long as the licensee entered into the agreement on or before July 1, 2000. *(Department of Insurance; 760 IAC 1-67-20; filed Aug 31, 2001, 9:40 a.m.: 25 IR 100)*

Rule 68. Multiple Employer Welfare Arrangements

760 IAC 1-68-1 Definitions

Authority: IC 27-1-34-9
Affected: IC 27-1-34-1

Sec. 1. The following definitions apply throughout this rule:

(1) "Commissioner" means the commissioner of the Indiana department of insurance.

(2) "Creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

(3) "Department" means the Indiana department of insurance.

(4) "Fund balance" means the total assets in excess of total liabilities, except that assets pledged to secure debts not reflected on the books of the multiple employer welfare arrangement are not included in the fund balance. The term includes other contributed capital, retained earnings, and subordinated debt.

(5) "Health benefit plan" means any plan that provides benefits for health care services. The term does not include the following:

(A) Accident-only or disability income insurance or a combination of accident-only and disability income insurance.
(B) Credit only insurance.
(C) Disability insurance.
(D) Coverage for a specified disease or illness.
(E) Medicare supplement policies.

(F) Long term care coverage.
(G) Workers' compensation insurance.
(H) A jointly managed trust authorized under 29 U.S.C. 141 et seq. with a plan of benefits for employees negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees as authorized under 29 U.S.C. 157.
(I) Hospital indemnity or fixed indemnity insurance.
(J) Reinsurance contract issued on a stop-loss, quota-share, or similar basis.
(K) Short term major medical contracts.
(L) Liability insurance.

(6) "Multiple employer welfare arrangement" or "MEWA" has the meaning set forth in IC 27-1-34-1.

(7) "Participant criteria" means any criteria or rules established by an employer to determine the employees who are eligible for enrollment, including continued enrollment, under the terms of a health benefit plan.

(8) "Participation agreement" means the document pursuant to which an employer undertakes and agrees to fulfill obligations as a member of the MEWA.

(9) "Qualified actuary" means an actuary who is not an employee of the MEWA and is a fellow of the Society of Actuaries, a member of the American Academy of Actuaries, or an enrolled actuary under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001, et seq.).

(10) "Qualified financial institution" means an institution that is organized or, in the case of a United States branch or agency office of a foreign banking organization, is licensed under the laws of the United States or any state and has been granted authority to operate with fiduciary powers and is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

(Department of Insurance; 760 IAC 1-68-1; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3035)

760 IAC 1-68-2 Certificate of registration

Authority: IC 27-1-34-9
Affected: IC 4-21.5-5; IC 27-1-25; IC 27-1-34

Sec. 2. (a) A MEWA may not engage in business in Indiana without first obtaining a certificate of registration from the department.

(b) To obtain a certificate of registration, a MEWA shall submit an application for a certificate of registration. The application shall be on a form prescribed by the department. The application shall be completed and submitted along with the following information:

(1) Copies of all articles, bylaws, agreements, trusts, or other documents describing the rights and obligations of employers, employees, and beneficiaries.

(2) Current financial statements of the MEWA and a projection of the assets, liabilities, income, and expenses of the MEWA for the next twelve (12) months.

(3) Proof of a fidelity bond, which shall protect against acts of fraud or dishonesty in servicing the MEWA, covering each person responsible for servicing the MEWA in an amount equal to:

(A) the greater of ten percent (10%) of the premiums and contributions received by the MEWA; or
(B) ten percent (10%) of the benefits paid;

during the preceding calendar year, with a minimum of ten thousand dollars ($10,000) and a maximum of five hundred thousand dollars ($500,000). No additional bond shall be required of a third party administrator licensed under IC 27-1-25.

(4) A business plan for the MEWA, including the proposed marketing and sales plan and documents.

(5) An opinion from a qualified actuary satisfactory to the commissioner showing that the MEWA will be operated in accordance with sound actuarial principles.

(6) A certification by the applicant that the MEWA is in compliance with all applicable provisions of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.) or that the applicant is exempt from the Employee Retirement Income Security Act of 1974 including the basis for the asserted exemption.

(7) Copies of the plan documents and agreements with service providers.

(8) A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and

other expenses associated with operation of the MEWA.

(9) Names and addresses of the following:

(A) The association or group of employers sponsoring the MEWA.

(B) The members of the board of trustees or directors, as applicable, of the MEWA.

(C) If not an association, at least two (2) employers.

(10) The application fee required by section 17 of this rule.

(c) The commissioner shall examine the application and documents submitted by the applicant and shall have the power to conduct any investigation the commissioner may deem necessary and to examine under oath any persons interested in or connected with the MEWA. The commissioner may request any additional information that he or she deems relevant to the application. A certificate of registration will not be issued until the commissioner approves the MEWA's application.

(d) To meet the requirements for approval of an application for a certificate of registration, a MEWA must meet all of the following conditions:

(1) The employers in the MEWA must be members of an association or group of two (2) or more businesses in the same trade or industry, including closely related businesses that provide support, services, or supplies primarily to that trade or industry. If an association, the association must:

(A) be engaged in substantial activity for its members other than sponsorship of an employee welfare benefit plan; and

(B) have been in existence for a period of not less than two (2) years prior to engaging in any activities relating to the provision of employee health benefits to its members.

(2) The MEWA must be controlled and sponsored directly by participating employers or participating employees, or both. The MEWA must be operated pursuant to a trust agreement by a board of trustees that has complete fiscal control over the MEWA and that is responsible for all operations of the MEWA. The trustees must be owners, partners, officers, directors, or employees of employers in the MEWA. The trustees must be equitably divided through the participating employers; no one (1) employer may be represented by a majority of the board.

(3) The MEWA must be a not-for-profit organization.

(4) Coverage under the MEWA must not be offered to persons or groups other than participating employers and, in the event of an association, the sponsoring association.

(5) The MEWA must have within its own organization adequate facilities and competent personnel, as determined by the commissioner, to service the employee benefit plan or must have contracted with a third party administrator holding a certificate of registration under IC 27-1-25.

(6) The MEWA must have applications from not less than two (2) employers and plan to provide similar benefits for not less than two hundred (200) participating employees. The annual gross premiums of or contributions to the plan must not be less than:

(A) twenty thousand dollars ($20,000) for a plan that provides only vision benefits;

(B) seventy-five thousand dollars ($75,000) for a plan that provides only dental benefits; and

(C) two hundred thousand dollars ($200,000) for all other plans.

(7) The MEWA must possess a written commitment, binder, or policy for stop-loss insurance issued by an insurer authorized to do business in this state providing:

(A) not less than sixty (60) days' notice to the commissioner of any cancellation or nonrenewal of coverage; and

(B) both specific and aggregate coverage with an aggregate retention of no more than one hundred twenty-five percent (125%) of the amount of expected claims for the next plan year and a specific retention amount annually determined by the actuarial report required by section 9 of this rule.

Both the specific and the aggregate coverage must require all claims to be submitted within ninety (90) days after the claim is incurred and provide a twelve (12) month claims incurred period and a fifteen (15) month paid claims period for each policy year.

(8) The contributions must be set to fund at least one hundred percent (100%) of the aggregate retention plus all other costs of the MEWA.

(9) The MEWA must establish a procedure acceptable to the commissioner for:

(A) handling claims for benefits in the event of dissolution of the MEWA; and

(B) the routine handling of claims.

(10) The MEWA must obtain the required bond.

(11) The MEWA must be operated in accordance with sound actuarial principles.

(12) All funds of the MEWA must be held in trust in the name of the MEWA in a qualified financial institution.

(13) The MEWA's participation application and participation agreement must contain the language required by section 16 of this rule.

(e) A denial of an application shall:

(1) be in writing;

(2) specify the reasons for denial; and

(3) provide notice of the applicant's right to request a hearing.

Any request for a hearing shall be submitted within thirty (30) days of receipt of the department's denial. A final order of the commissioner is a final order subject to judicial review pursuant to IC 4-21.5-5.

(f) A certificate of registration shall be renewed annually on a form prescribed by the department. The MEWA shall update any information required by section 2(b) *[subsection (b)]* or attest in writing that there were no material changes to the information previously submitted under section 2(b) *[subsection (b)]*.

(g) A MEWA in existence on January 1, 2003, shall do the following:

(1) File notice with the commissioner by July 1, 2003, of its intent to apply for an initial certificate of registration.

(2) File for its initial certificate of registration by October 1, 2003.

The MEWA may continue to conduct business until the certificate of registration is granted or denied by the commissioner. *(Department of Insurance; 760 IAC 1-68-2; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3036)*

760 IAC 1-68-3 Eligibility

Authority: IC 27-1-34-9
Affected: IC 27-1-34

Sec. 3. A MEWA may only provide benefits to active or retired owner, officers, directors, or employees of or partners in participating employers, or the dependents of such persons, except as otherwise limited by the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.). *(Department of Insurance; 760 IAC 1-68-3; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3038)*

760 IAC 1-68-4 Coverage requirements

Authority: IC 27-1-34-9
Affected: IC 25-22.5; IC 25-29; IC 27-1-34

Sec. 4. (a) A MEWA may refuse to provide coverage to an employer employing fifty (50) or more employees in accordance with the MEWA's underwriting standards and criteria. The MEWA shall accept or reject the entire group of individuals who meet the participation criteria and who choose coverage. The MEWA may exclude only those individuals who have declined coverage. Denial by a MEWA of an application for coverage from an employer must be in writing and must state the reason or reasons for the denial.

(b) A MEWA must provide coverage to any employer that meets the participating employer criteria and who employs two (2) to fifty (50) employees.

(c) Upon issuance of coverage to any employer, each MEWA shall provide coverage to the employees who meet the participation criteria established by the terms of the plan document without regard to an individual's health status related factors. The participation criteria may not be based on health status factors.

(d) The MEWA shall obtain a written waiver for each employee who meets the participation criteria and who declines coverage under the MEWA. The waiver must ensure that the employee was not induced or pressured into declining coverage because of the employee's or a dependent's health status.

(e) A MEWA may not provide coverage to an employer or the employees of an employer if the MEWA or an agent for the MEWA knows that the employer has induced or pressured an employee who meets the participation criteria or a dependent of the employee to decline coverage because of that individual's health status.

(f) A MEWA may require an employer to meet minimum contribution or participation requirements as a condition of issuance and renewal in accordance with the terms of the MEWA's plan document. Those requirements shall be:

(1) stated in the plan document; and

(2) applied uniformly to each employer offered or issued coverage by the MEWA.

(g) The initial enrollment period for employees meeting the participation criteria must be at least thirty-one (31) days, with a thirty-one (31) day annual open enrollment period. If dependent coverage is offered, the dependent's open enrollment must also comply with these time periods.

(h) A MEWA may establish a waiting period during which a new employee is not eligible for coverage in accordance with the plan document.

(i) A MEWA's plan document may not, by use of a rider or amendment applicable to a specific individual, limit or exclude coverage by type of illness, treatment, medical condition, or accident, except for preexisting conditions as follows:

(1) A preexisting condition provision in a MEWA may not apply to an expense incurred on or after the expiration of the twelve (12) months following the initial effective date of coverage of the participating employee or dependent. However, this time period may be extended to eighteen (18) months for a late enrollee as defined in the federal Health Insurance Portability and Accountability Act of 1996.

(2) A preexisting condition provision in a MEWA plan document may not apply to coverage for a disease or condition other than a disease or condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months before the earlier of the:

(A) effective date of coverage; or

(B) first day of the waiting period.

(3) A MEWA shall not treat genetic information as a preexisting condition in the absence of a diagnosis of the condition related to the information.

(4) A MEWA shall not treat a pregnancy as a preexisting condition.

(5) A preexisting condition provision in a MEWA's plan document may not apply to an individual who was continuously covered for a period of twelve (12) months under creditable coverage that was in effect up to a date not more than sixty-three (63) days before the effective date of coverage under the health benefit plan, excluding any waiting period.

(6) In determining whether a preexisting condition provision applies to an individual covered by a MEWA's plan document, the MEWA shall credit the time the individual was covered under previous creditable coverage if the previous coverage was in effect at any time during the twelve (12) months preceding the effective date of coverage under the MEWA. If the previous coverage was issued under a health benefit plan, any waiting period shall also be credited to the preexisting condition provision period.

(7) This section does not preclude application of any waiting period applicable to all new participating employees under the health benefit plan in accordance with the terms of the MEWA's plan document.

(j) A MEWA shall provide that the benefits applicable to an individual or family member shall be payable with respect to a newly born or adopted child of a covered person. The coverage shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage shall include, but not be limited to, benefits for inpatient or outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate. If payment of a specific premium or fee is required to provide coverage for a child, the policy or contract may require that notification of the birth or adoption and payment of the required premium or fee must be furnished to the MEWA within thirty-one (31) days after the date of birth or adoption in order to have continuous coverage beyond the thirty-one (31) day period.

(k) Coverage offered by the MEWA shall comply with the following:

(1) The federal Women's Health and Cancer Rights Act.

(2) The federal Mental Health Parity Act.

(3) The federal Pregnancy Discrimination Act.

(l) The MEWA shall comply with the federal Health Insurance Portability and Accountability Act of 1996.

(m) The MEWA shall provide coverage for the following:

(1) The medically necessary treatment for diabetes, including medically necessary supplies and equipment as ordered in writing by a physician licensed under IC 25-22.5 or a podiatrist licensed under IC 25-29, subject to general provisions of the health benefit plan.

(2) At least one (1) prostate specific antigen test annually for an insured who is at least fifty (50) years of age or is younger than fifty (50) years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

(3) Colorectal cancer examinations and laboratory tests for cancer for any nonsymptomatic insured, in accordance with the current American Cancer Society guidelines for a covered individual who is fifty (50) years of age or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

(n) A MEWA may not deny enrollment of a child of a covered individual because the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the MEWA's service area. Whenever a child of a noncustodial parent is eligible for coverage with or covered by the MEWA the MEWA shall do the following:

(1) Provide any information to the custodial parent that is necessary for the child to obtain benefits through the MEWA.

(2) Permit the custodial parent, or the provider of medical services with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent.

(3) Make payments on insurance claims submitted under subdivision (2) directly to the custodial parent, the provider of the medical services, or the office of Medicaid policy and planning.

(4) When a parent is required by a court or an administrative order to provide health coverage for a child and the parent is eligible for family health coverage with the MEWA, the MEWA must do all of the following:

(A) Permit the parent to enroll under the family coverage a child who is otherwise eligible for the coverage, without regard to any enrollment season restriction.

(B) Enroll a child under the family coverage upon application by the child's custodial parent, the office of Medicaid policy and planning, or a Title IV-D agency whenever a noncustodial parent who is enrolled fails to apply for coverage of the child.

(C) The MEWA may not disenroll or eliminate coverage of a child who is otherwise eligible for coverage unless the MEWA is provided satisfactory written evidence that the court order or administrative order is no longer in effect or the child is or will be enrolled in comparable health coverage not later than the effective date of the disenrollment.

(o) If the MEWA coordinates benefits, the coordination of benefits provision must comply with 760 IAC 1-38.1. *(Department of Insurance; 760 IAC 1-68-4; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3038)*

760 IAC 1-68-5 Applications

Authority: IC 27-1-34-9
Affected: IC 27-1-34

Sec. 5. (a) A MEWA, in its application for coverage, may ask questions of a medically specific nature that are necessary to render a fully informed underwriting determination, based upon sound actuarial principles concerning whether to accept or rate a particular risk, subject to the following conditions:

(1) Questions relating to medical and other factual matters intending to reveal the possible existence of medical conditions are permissible if the applicant has been given an opportunity to provide an explanation for any affirmative answers given in the application. Questions shall:

(A) be related to a finite period of time preceding completion of the application;

(B) be specific and objective; and

(C) provide the applicant the opportunity to give a detailed explanation.

(2) No question in an application shall be directed towards determining or designed to establish the applicant's sexual orientation.

(3) Questions relating to the applicant having human immunodeficiency virus or having been diagnosed as having human immunodeficiency virus are permissible if they are factual, objective, and designed to establish the existence of the condition.

(b) A MEWA may require a potential covered individual to submit to any medical tests, at the insurer's expense, the purpose of which is to determine infection with human immunodeficiency virus, subject to the following conditions:

(1) The test is necessary to render a fully informed underwriting determination based upon sound actuarial principles concerning whether to accept or rate a particular risk.

(2) Whenever an applicant is requested to take a test to determine human immunodeficiency virus infection, the use of such a test must be revealed to the applicant and his or her written consent obtained. No adverse underwriting decision shall be made on the basis of such a positive test unless an established test protocol has been followed.

(3) The following test protocol is established and must be the basis of an adverse underwriting determination:

(A) Two (2) positive ELISA tests.

(B) One (1) Western Blot test, which is not negative, must be obtained from the same sample from tests conducted by a qualified laboratory.

(4) All results of tests to determine human immunodeficiency virus infection and application responses are confidential and shall not be shared with anyone other than the applicant, the applicant's physician, and the MEWA's underwriting department, except as follows:

(A) Test results and application responses may be shared with underwriting departments of affiliates of the MEWA and reinsurers, who shall be subject to all provisions of this rule as if they were the MEWA to which application was originally made.

(B) Test results may be reported to the Medical Information Bureau, Inc., provided that:

(i) the MEWA will not report that tests of an applicant showed the presence of human immunodeficiency virus, but only that unspecified test results were abnormal; and

(ii) reports must use a general code that also covers results of tests for many diseases or conditions that are not related to human immunodeficiency virus or acquired immune deficiency syndrome.

(5) A MEWA may make an underwriting or a rating determination based upon questions asked and tests required pursuant to this subsection, subject to the following conditions:

(A) Sexual orientation may not be used in the underwriting process or in the determination of insurability.

(B) Support organizations shall be directed by insurers not to investigate, directly or indirectly, the sexual orientation of an applicant or a beneficiary.

(C) Neither the marital status, the living arrangements, the occupation, the gender, the medical history, the beneficiary designation, nor the zip code or other territorial classification of an applicant may be used to establish, or aid in establishing, the applicant's sexual orientation.

(D) For purposes of rating a group for health, a MEWA may impose territorial rates, but only if the rates are based on sound actuarial principles or are related to actual or reasonably anticipated experience.

(E) No adverse underwriting decision shall be made because medical records or a report from a support organization shows that the applicant has demonstrated concern about human immunodeficiency virus by seeking testing or counseling from health care professionals. This subsection does not apply to an applicant seeking treatment or diagnosis for a specific condition.

(6) In the event a MEWA determines to accept a risk, it must do so without limitations or exclusions solely of the coverage for human immunodeficiency virus, acquired immune deficiency syndrome, or a related condition, as follows:

(A) No maximum dollar amount of coverage, which is limited solely to human immunodeficiency virus, acquired immune deficiency syndrome, or a related condition, shall be included in any policy or certificate.

(B) No exclusion of coverage, which is limited solely to human immunodeficiency virus, acquired immune deficiency syndrome, or a related condition, shall be included in any policy or certificate.

(Department of Insurance; 760 IAC 1-68-5; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3039)

760 IAC 1-68-6 Premium rates

Authority: IC 27-1-34-9
Affected: IC 27-1-34

Sec. 6. A MEWA may not charge an adjustment to premium rates for individual employees or dependents for health status related factors or duration of coverage. Any adjustment must be applied uniformly to the rates charged for all participating employees and dependents of participating employees of the employer. *(Department of Insurance; 760 IAC 1-68-6; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3040)*

760 IAC 1-68-7 Marketing practices

Authority: IC 27-1-34-9
Affected: IC 27-1-34

Sec. 7. (a) On request, the MEWA shall provide an employer with a summary of the plans for which the employer is eligible.

All marketing materials shall include the disclosure required by section 16 of this rule.

(b) The department may require periodic reports by MEWAs and agents regarding health benefit plans issued by MEWAs. *(Department of Insurance; 760 IAC 1-68-7; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3041)*

760 IAC 1-68-8 Third party administrator

Authority: IC 27-1-34-9
Affected: IC 27-1-25; IC 27-1-34

Sec. 8. (a) If a MEWA enters into an agreement with a third party administrator to provide administrative, marketing, or other services related to the offering of health benefits plans to employers in this state, the third party administrator must hold a certificate of registration issued under IC 27-1-25.

(b) A trustee may not be an owner, officer, or employee of the administrator. *(Department of Insurance; 760 IAC 1-68-8; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3041)*

760 IAC 1-68-9 Filings by multiple employer welfare arrangement

Authority: IC 27-1-34-9
Affected: IC 27-1-34

Sec. 9. (a) Each MEWA shall file the following information on a quarterly basis, and the filing is due forty-five (45) days after the end of the MEWA's fiscal quarter:

(1) Quarterly financial statements, including a balance sheet and income statement prepared in accordance with generally accepted accounting principles signed by an officer of the MEWA.

(2) A list of any employers who have obtained coverage with the MEWA during the previous quarter and the number of their covered employees.

(b) Each MEWA transacting business in this state shall file an annual report with the commissioner within ninety (90) days of the end of the MEWA's fiscal year. The report shall be verified by the oath of the chair of the board of trustees. The report must summarize the business activities of the trust for the immediately preceding year and must contain all of the following items:

(1) Management discussion and analysis.

(2) Financial statements audited by a certified public accountant.

(3) An actuarial opinion prepared and certified by a qualified actuary that states:

(A) The MEWA is being operated in accordance with sound actuarial principles.

(B) A description and explanation of actuarial assumptions and actuarial methods.

(C) The recommended level of specific and aggregate stop-loss insurance the MEWA should maintain.

(4) A statement detailing any modified terms of a plan document along with a certification from the trustees that any changes are in compliance with the minimum requirements of this rule.

(5) If the MEWA has been examined by a regulatory authority, the report shall:

(A) identify the entity that conducted the examination; and

(B) include a copy of the examination report.

(6) The names and addresses of all participating employers and the total number of covered individuals.

(c) Each filing made with the department shall be accompanied by the filing fee required by section 17 of this rule. *(Department of Insurance; 760 IAC 1-68-9; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3041)*

760 IAC 1-68-10 Financial condition

Authority: IC 27-1-34-9
Affected: IC 27-1-34

Sec. 10. Each MEWA shall maintain a minimum fund balance of five hundred thousand dollars ($500,000). *(Department of Insurance; 760 IAC 1-68-10; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3041)*

760 IAC 1-68-11 Examination

Authority: IC 27-1-34-9
Affected: IC 27-1-3.1; IC 27-1-34-6

Sec. 11. (a) The commissioner or any person appointed by the commissioner shall have the power to examine the affairs of any MEWA and for such purposes shall have free access to all the books, records, and document that relate to the business of the plan and may examine under oath its trustees or directors, officers, agents, and employees in relation to the affairs, transactions, and conditions of the MEWA. Expenses of the examination shall be paid by the MEWA as provided in IC 27-1-34-6. The examination shall be conducted and in accordance with IC 27-1-3.1 and may cover financial or market conduct issues.

(b) Each MEWA must have and maintain a place of business in Indiana and must make available to the commissioner complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary for or suitable to the kind or kinds of business transacted. *(Department of Insurance; 760 IAC 1-68-11; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3041)*

760 IAC 1-68-12 Forms

Authority: IC 27-1-34-9
Affected: IC 4-21.5; IC 27-1-34

Sec. 12. (a) No participation agreement or contract form, application form, certificate, rider, endorsement, summary plan description, or other evidence of coverage may be issued unless the form, and any subsequent changes to the form, has been filed with the commissioner. The form may not be used for thirty (30) days after the filing unless the commission gives written approval of the form before the expiration of thirty (30) days.

(b) The commissioner may, within thirty (30) days after the filing of a form, disapprove the form if the form:

(1) violates or does not comply with this rule or any applicable statute;

(2) contains or incorporates by reference inconsistent, ambiguous, or misleading clauses or exceptions and conditions that deceptively affect the risk proposed to be assumed in the general coverage of the contract;

(3) has any title heading or other indication of its provision that is misleading;

(4) is printed or otherwise reproduced in such manner as to render any material provision of the form substantially illegible; or

(5) contains any provision that is unfair, inequitable, or encourages misrepresentation.

(c) A disapproval must:

(1) be in writing; and

(2) identify the reason for the denial and provide an opportunity for a hearing on the matter.

(d) The commissioner may, after notice and a hearing, withdraw approval of a form for the reasons stated in subsection (b).

(e) Any final order of the commissioner under this section is a final order and subject to judicial review under IC 4-21.5-5.

(f) All filings under this section shall be accompanied by the filing fee required by section 17 of this rule. *(Department of Insurance; 760 IAC 1-68-12; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3042)*

760 IAC 1-68-13 Enforcement

Authority: IC 27-1-34-9
Affected: IC 27-1-34

Sec. 13. (a) The commissioner may deny, suspend, or revoke a certificate of registration if, after notice and a hearing, the commissioner finds that the MEWA has failed to meet the requirements of this rule or any applicable statute.

(b) The commissioner shall deny, suspend, or revoke the certificate of registration of a MEWA if the commissioner finds any of the following exist:

(1) The MEWA has a negative fund balance.

(2) The MEWA has refused to:

(A) be examined; or

(B) produce the MEWA's accounts, records, and files for examination;

or any of the MEWA's officers have refused to give information with respect to the MEWA's affairs to perform any other

legal obligation as to such examination when required by the commissioner.

(3) The MEWA has failed to pay a final judgment rendered against it in court within thirty (30) days.

(4) The MEWA no longer meets the requirements for the authority originally granted.

(Department of Insurance; 760 IAC 1-68-13; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3042)

760 IAC 1-68-14 Termination

Authority: IC 27-1-34-9
Affected: IC 27-1-34

Sec. 14. If a MEWA is terminated for any reason, the trust may not be dissolved until all outstanding financial obligations of the MEWA are paid. The MEWA may retain sufficient funds to provide coverage for an additional period as the trustees of the MEWA consider prudent. The trustees may purchase additional insurance for protection against potential future claims. Any funds remaining in the MEWA after satisfaction of all obligations must be paid to participating employers or covered employees in an equitable manner meeting with the approval of the commissioner. Written notice of the termination must be provided to each covered employee, the United States Department of Labor, and the commissioner at least thirty (30) days before the effective date of the termination. *(Department of Insurance; 760 IAC 1-68-14; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3042)*

760 IAC 1-68-15 Liability of participants

Authority: IC 27-1-34-9
Affected: IC 27-1-34

Sec. 15. (a) The liability of each employer participant for the obligations of the MEWA is joint and several.

(b) Each employer participant has a contingent assessment liability pursuant to this section for payment of actual losses and expenses incurred while the participation agreement was in force.

(c) Each participation agreement or contract issued by the MEWA must contain a statement of the contingent liability of employer participants. Both the application for participation and the participation agreement must contain, in contrasting color and not less than twelve (12) point type, the statement, "This is a fully assessable contract. In the event (the MEWA) is unable to pay its obligations, participating employers will be required to contribute through an equitable assessment the money necessary to meet any unfulfilled obligations.". *(Department of Insurance; 760 IAC 1-68-15; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3042)*

760 IAC 1-68-16 Written notice

Authority: IC 27-1-34-9
Affected: IC 27-1-34

Sec. 16. (a) A MEWA shall provide to each participating employer the written notice, "In the event the plan or the MEWA does not ultimately pay medical expenses that are eligible for payment under the plan for any reason, the participating employer may be liable for those expenses.".

(b) Every application and coverage form, including certificates of coverage, must contain in not less than twelve (12) point type the notice, "Your coverage is issued by a multiple employer welfare arrangement. The multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State insurance guaranty funds are not available for your multiple employer welfare arrangement.". *(Department of Insurance; 760 IAC 1-68-16; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3043)*

760 IAC 1-68-17 Fees

Authority: IC 27-1-34-9
Affected: IC 27-1-34

Sec. 17. The following fees apply to MEWAs:

(1) An applicant shall pay a nonrefundable fee of three hundred fifty dollars ($350) for filing an application for a certificate of registration.

(2) Each MEWA holding a certificate of registration shall pay an annual internal audit fee of one hundred dollars ($100).

(3) A fee of fifty dollars ($50) shall accompany the filing of the annual report required by section 9 of this rule.
(4) A fee of thirty-five dollars ($35) shall accompany each form filed as required by section 12 of this rule.
(Department of Insurance; 760 IAC 1-68-17; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3043)

760 IAC 1-68-18 Fully insured MEWAs
Authority: IC 27-1-34-9
Affected: IC 27-1-34

Sec. 18. This rule does not apply to a fully insured MEWA. A fully insured MEWA is a MEWA that provides benefits to its participating employees and beneficiaries for which one hundred percent (100%) of the liability has been assumed by an insurance company or health maintenance organization holding a certificate of authority in Indiana. The covered individual must be entitled to make a claim for payment directly to the insurance company or health maintenance organization. *(Department of Insurance; 760 IAC 1-68-18; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3043)*

760 IAC 1-68-19 Severability
Authority: IC 27-1-34-9
Affected: IC 27-1-34

Sec. 19. If any section or portion of a section of this rule or its applicability to any person or circumstance is held invalid by a court, the remainder of the rule or the applicability of the provision to other persons or circumstances shall not be affected. *(Department of Insurance; 760 IAC 1-68-19; filed Apr 15, 2003, 2:20 p.m.: 26 IR 3043)*

Rule 69. Recognition of the 2001 CSO Mortality Table for Use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits

760 IAC 1-69-1 Definitions
Authority: IC 27-1-3-7; IC 27-1-12-7; IC 27-1-12-10; IC 27-1-12-10.5
Affected: IC 27-1-12-7; IC 27-1-12-10; IC 27-1-12-10.5

Sec. 1. The following definitions apply throughout this rule:
(1) "2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the National Association of Insurance Commissioners in December 2002. Unless the context indicates otherwise, the term includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.
(2) "2001 CSO Mortality Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.
(3) "2001 CSO Mortality Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.
(4) "Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.
(5) "Smoker and nonsmoker mortality tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.
(Department of Insurance; 760 IAC 1-69-1; filed Oct 29, 2003, 2:30 p.m.: 27 IR 872, eff Jan 1, 2004)

760 IAC 1-69-2 2001 CSO Mortality Table
Authority: IC 27-1-3-7; IC 27-1-12-7; IC 27-1-12-10; IC 27-1-12-10.5
Affected: IC 27-1-12-7; IC 27-1-12-10; IC 27-1-12-10.5

Sec. 2. (a) At the election of the company for any one (1) or more specified plans of insurance and subject to the conditions stated in this rule, the 2001 CSO Mortality Table may be used as the minimum standard for policies issued on or after January 1, 2004, and before the date specified in subsection (b) to which IC 27-1-12-10(2), IC 27-1-12-7(dd), 760 IAC 1-64-3(a), and 760 IAC 1-64-3(b) are applicable. If the company elects to use the 2001 CSO Mortality Table, it shall do so for both valuation and nonforfeiture purposes.

(b) Subject to the conditions stated in this rule, the 2001 CSO Mortality Table shall be used in determining minimum standards for policies issued on and after January 1, 2009, to which IC 27-1-12-10(2), IC 27-1-12-7(dd), 760 IAC 1-64-3(a), and 760 IAC 1-64-3(b) are applicable. *(Department of Insurance; 760 IAC 1-69-2; filed Oct 29, 2003, 2:30 p.m.: 27 IR 872, eff Jan 1, 2004)*

760 IAC 1-69-3 Conditions

Authority: IC 27-1-3-7; IC 27-1-12-7; IC 27-1-12-10; IC 27-1-12-10.5
Affected: IC 27-1-12-7; IC 27-1-12-10; IC 27-1-12-10.5

Sec. 3. (a) For each plan of insurance with separate rates for smokers and nonsmokers, an insurer may use any of the following:

(1) Composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

(2) Smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by IC 27-1-12-10(6) and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values, and amounts of paid-up nonforfeiture benefits.

(3) Smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

(b) For plans of insurance without separate rates for smokers and nonsmokers, the composite mortality tables shall be used.

(c) For the purpose of determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, the 2001 CSO Mortality Table may, at the option of the company for each plan of insurance, be used in its ultimate or select and ultimate form, subject to the restrictions of 760 IAC 1-64 relative to use of the select and ultimate form.

(d) When the 2001 CSO Mortality Table is the minimum reserve standard for any plan for a company, the actuarial opinion in the annual statement filed with the commissioner shall be based on an asset adequacy analysis as specified in 760 IAC 1-57-8. *(Department of Insurance; 760 IAC 1-69-3; filed Oct 29, 2003, 2:30 p.m.: 27 IR 872, eff Jan 1, 2004)*

760 IAC 1-69-4 Applicability of the 2001 CSO Mortality Table to 760 IAC 1-64

Authority: IC 27-1-3-7; IC 27-1-12-7; IC 27-1-12-10; IC 27-1-12-10.5
Affected: IC 27-1-12-7; IC 27-1-12-10; IC 27-1-12-10.5

Sec. 4. (a) The 2001 CSO Mortality Table may be used in applying 760 IAC 1-64 in the following manner, subject to the transition dates for use of the 2001 CSO Mortality Table in section 2 of this rule:

(1) 760 IAC 1-64-1(c)(3)(B): The net level reserve premium is based on the ultimate mortality rates in the 2001 CSO Mortality Table.

(2) 760 IAC 1-64-2(d): All calculations are made using the 2001 CSO Mortality Rate and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in subdivision (4). The value of q_{x+k-1} is the valuation mortality rate for deficiency reserves in policy year k+t, but using the unmodified select mortality rates if modified select mortality rates are used in the computation of deficiency reserves.

(3) 760 IAC 1-64-3(a): The 2001 CSO Mortality Table is the minimum standard for basic reserves.

(4) 760 IAC 1-64-3(b): The 2001 CSO Mortality Table is the minimum standard for deficiency reserves. If select mortality rates are used, they may be multiplied by X percent for durations in the first segment, subject to the conditions specified in 760 IAC 1-64-3(b)(3)(A) through 760 IAC 1-64-3(b)(3)(I). In demonstrating compliance with those conditions, the demonstrations may not combine the results of tests that utilize the 1980 CSO Mortality Table with those tests that utilize the 2001 CSO Mortality Table unless the combination is explicitly required by rule or necessary to be in compliance with relevant Actuarial Standards of Practice.

(5) 760 IAC 1-64-4(c): The valuation mortality table used in determining the tabular cost of insurance shall be the ultimate

mortality rates in the 2001 CSO Mortality Table.

(6) 760 IAC 1-64-4(e)(4): The calculations specified in 760 IAC 1-64-4(e) shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(7) 760 IAC 1-64-4(f)(4): The calculations specified in 760 IAC 1-64-4(f) shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(8) 760 IAC 1-64-4(g)(2): The calculations specified in 760 IAC 1-64-4(g) shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(9) 760 IAC 1-64-5(a)(1)(B): The one (1) year valuation premium shall be calculated using the ultimate mortality rates in the 2001 CSO Mortality Table.

(b) Nothing in this section shall be construed to expand the applicability of 760 IAC 1-64 to include life insurance policies exempted under 760 IAC 1-64-1(c). *(Department of Insurance; 760 IAC 1-69-4; filed Oct 29, 2003, 2:30 p.m.: 27 IR 872, eff Jan 1, 2004)*

760 IAC 1-69-5 Gender-blended tables

Authority: IC 27-1-3-7; IC 27-1-12-7; IC 27-1-12-10; IC 27-1-12-10.5
Affected: IC 27-4-1-4

Sec. 5. (a) For any ordinary life insurance policy delivered or issued for delivery in this state on and after January 1, 2004, that utilizes the same premium rates and charges for male and female lives or is issued in circumstances where applicable law does not permit distinctions on the basis of gender, a mortality table that is a blend of the 2001 CSO Mortality Table (M) and the 2001 CSO Mortality Table (F) may, at the option of the company for each plan of insurance, be substituted for the 2001 CSO Mortality Table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. No change in minimum valuation standards is implied by this provision.

(b) The company may choose from among the blended tables developed by the American Academy of Actuaries CSO Task Force and adopted by the National Association of Insurance Commissioners in December 2002.

(c) It shall not, in and of itself, be a violation of IC 27-4-1-4 for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis. *(Department of Insurance; 760 IAC 1-69-5; filed Oct 29, 2003, 2:30 p.m.: 27 IR 873, eff Jan 1, 2004)*

760 IAC 1-69-6 Incorporation by reference

Authority: IC 27-1-3-7; IC 27-1-12-7; IC 27-1-12-10; IC 27-1-12-10.5
Affected: IC 27-4-1-4

Sec. 6. The 2001 Commissioner's Standard Ordinary Mortality Tables are incorporated by reference as a part of this rule. These documents are available for public review at the department. *(Department of Insurance; 760 IAC 1-69-6; filed Oct 29, 2003, 2:30 p.m.: 27 IR 873, eff Jan 1, 2004)*

ARTICLE 2. LONG TERM CARE INSURANCE COVERAGE

Rule 1. General Provisions

760 IAC 2-1-1 Applicability and scope

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. Except as otherwise specifically provided, this article applies to the following:

(1) All long term care insurance policies, certificates, or subscriber agreements delivered or issued for delivery, in Indiana on or after the effective date hereof, by insurers.

(2) Fraternal benefit societies.

(3) Nonprofit health, hospital, and medical service corporations.

(4) Prepaid health plans.

(5) Health maintenance organizations and all similar organizations.

(Department of Insurance; 760 IAC 2-1-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 856; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 2. Definitions

760 IAC 2-2-1 Policy definitions

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) No long term care insurance policy, certificate, or subscriber agreement delivered, or issued for delivery, in Indiana shall contain the terms set forth in this rule, unless the terms are defined in the policy and the definitions satisfy the requirements in this section.

(b) All providers of services, including, but not limited to:

(1) skilled nursing facility;

(2) extended care facility;

(3) intermediate care facility;

(4) convalescent nursing home;

(5) personal care facility; and

(6) home care agency;

shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

(c) The definitions in this rule apply throughout this article. *(Department of Insurance; 760 IAC 2-2-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 856; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-2-2 "Acute condition" defined

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status. *(Department of Insurance; 760 IAC 2-2-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 856; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-2-3 "Adult day care" defined

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3. "Adult day care" means a program for six (6) or more individuals, of social and health related services provided during the day in a community group setting for the purpose of supporting frail, impaired, elderly, or other adults with disabilities who can benefit from care in a group setting outside the home. *(Department of Insurance; 760 IAC 2-2-3; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-2-4 "Home health care services" defined

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 4. "Home health care services" means medical and nonmedical services provided to ill, disabled, or infirm persons in their residences. Such services may include, but are not limited to, the following:

(1) Home health nursing services.

(2) Home health aide services.
(3) Homemaker services.
(4) Assistance with activities of daily living.
(5) Respite care services.

(Department of Insurance; 760 IAC 2-2-4; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-2-5 "Medicare" defined

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 5. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import. *(Department of Insurance; 760 IAC 2-2-5; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-2-6 "Mental or nervous disorder" defined

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 6. "Mental or nervous disorder" includes only neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder. *(Department of Insurance; 760 IAC 2-2-6; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-2-7 "Personal care" defined

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 7. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living (such as bathing, eating, dressing, transferring, and toileting). *(Department of Insurance; 760 IAC 2-2-7; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-2-8 "Skilled nursing care", "intermediate care", and "home care" defined

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 8. "Skilled nursing care", "intermediate care", "home care", and other services shall be defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered. *(Department of Insurance; 760 IAC 2-2-8; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 3. Policy Practices and Provisions

760 IAC 2-3-1 Individual long term care policies

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) The terms "guaranteed renewable" and "noncancellable" shall be used in an individual long term care insurance policy only with further explanatory language in accordance with the disclosure requirements of 760 IAC 2-4.

(b) A long term care insurance policy issued to an individual shall not contain renewal provisions other than "guaranteed

renewable" or "noncancellable".

(c) The term "guaranteed renewable" may be used only when:

(1) the insured has the right to continue the long term care insurance in force by the timely payment of premiums;

(2) when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force; and

(3) the insurer cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(d) The term "noncancellable" may be used only when:

(1) the insured has the right to continue the long term care insurance in force by the timely payment of premiums; and

(2) the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(Department of Insurance; 760 IAC 2-3-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-3-2 Exclusions

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. A policy, certificate, or subscriber agreement may not be delivered or issued for delivery in Indiana as long term care insurance if the policy, certificate, or subscriber agreement limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

(1) Preexisting conditions or diseases.

(2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or related degenerative and dementing illnesses.

(3) Alcoholism and drug addiction.

(4) Illness, treatment, or medical condition arising out of:

(A) war or act of war (whether declared or undeclared);

(B) participation in a felony, riot, or insurrection;

(C) service in the armed forces or units auxiliary thereto;

(D) suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or

(E) aviation (this exclusion applies only to nonfare paying passengers).

(5) Treatment provided in a government facility, unless otherwise required by law as follows:

(A) Services for which benefits are available under any of the following:

(i) Medicare or other governmental program (except Medicaid).

(ii) Any state or federal workers' compensation.

(iii) Employer's liability or occupational disease law.

(iv) Any motor vehicle no-fault law.

(B) Services provided by a member of the covered person's immediate family.

(C) Services for which no charge is normally made in the absence of insurance.

This section is not intended to prohibit exclusions and limitations by type of provider or territorial limitations. *(Department of Insurance; 760 IAC 2-3-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 858; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-3-3 Termination; extension of benefits

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3. Termination of long term care insurance shall not prejudice any benefits payable for institutionalization if the institutionalization began while the long term care insurance was in force and which institutionalization continues without interruption after termination. The extension of benefits beyond the period the long term care insurance was in force may be limited to the following:

(1) The duration of the benefit period, if any.

(2) Payment of the maximum benefits, if any.

Further, such extension of benefits may be subject to any policy waiting period and all other applicable provisions of the policy. *(Department of Insurance; 760 IAC 2-3-3; filed Oct 30, 1992, 12:00 p.m.: 16 IR 858; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-3-4 Group long term care policies

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 4. (a) Group long term care insurance policies, certificates, or subscriber agreements issued in Indiana on or after the effective date of this article shall provide covered individuals with a basis for continuation or conversion of coverage.

(b) As used in this article, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium. Group policies which contain incentives to use certain providers and/or facilities, and group policies which provide a restricted list of providers and/or facilities shall provide continuation of benefits which are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits. The commissioner shall consider the differences between managed care and nonmanaged care plans, including, but not limited to, the following:

(1) Provider system arrangements.
(2) Service availability.
(3) Benefit levels.
(4) Administrative complexity.

(c) As used in this article, "a basis for conversion of coverage" means a policy provision which requires that an individual:

(1) whose coverage under the group policy would otherwise terminate or has been terminated for any reason; and

(2) who has been continuously insured under the group policy (and any group policy which it replaced) for at least six (6) months immediately prior to termination;

shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(d) As used in this article, "converted policy" means an individual policy of long term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, the following:

(1) Provider system arrangements.
(2) Service availability.
(3) Benefit levels.
(4) Administrative complexity.

(e) In order to maintain uninterrupted coverage, written application for the converted policy must be made and the first premium due, if any, must be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy or thirty-one (31) days after the date notification of conversion rights is mailed to the certificate holder, whichever is later. The converted policy shall be issued effective on the day following the termination of coverage under the group policy and shall be renewable annually.

(f) If the group policy from which conversion is made:

(1) did not replace previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made; or

(2) replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(g) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(1) termination of the individual's group coverage resulted from the individual's failure to make any required payment of premium or contribution when due; or

(2) the terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

(A) providing benefits identical to those provided by the terminating coverage or providing benefits which the commissioner determines to be substantially equivalent to or in excess of the benefits provided by the terminating coverage;

(B) the premium is calculated in a manner consistent with the requirements of subsection (f); and

(C) the new policy provides coverage to all individuals previously covered under the replaced policy.

(h) Notwithstanding any other provision of this rule, a converted policy issued to an individual may provide for a reduction of benefits payable to an individual only if:

(1) at the time of conversion, the individual is covered by another long term care insurance policy which provides benefits on the basis of incurred expenses;

(2) the benefits provided by the other long term care policy together with the full benefits provided by the converted policy would result in payment of more than one hundred percent (100%) of the incurred expenses; and

(3) the reduction in benefits may only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(i) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(j) Notwithstanding any other provision of this rule, any insured individual whose eligibility for group long term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship. *(Department of Insurance; 760 IAC 2-3-4; filed Oct 30, 1992, 12:00 p.m.: 16 IR 858; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-3-5 Replacement

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 5. If a group long term care policy, certificate, or subscriber agreement is replaced by another group long term care policy, certificate, or subscriber agreement issued to the same policyholder or to the members of the previous policyholder's group, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

(1) shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(2) shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long term care services.

(Department of Insurance; 760 IAC 2-3-5; filed Oct 30, 1992, 12:00 p.m.: 16 IR 859; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-3-6 Premiums

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 6. The premiums charged to an insured for long term care insurance shall not increase due to either:

(1) the increasing age of the insured at ages beyond sixty-five (65); or

(2) the duration the insured has been covered under the policy.

This limitation shall not be required of life insurance policies or riders containing accelerated long term care benefits. *(Department of Insurance; 760 IAC 2-3-6; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1391; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 4. Required Disclosure Provisions

760 IAC 2-4-1 Renewability provisions

Authority: IC 27-8-12-7
Affected: IC 27-8-12-10.6

Sec. 1. (a) Individual long term care insurance policies shall contain a renewability provision. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and the duration of the term of coverage for which the policy may be renewed. This section shall not apply to policies which do not contain a renewability provision, and under which the policies' right to nonrenew is reserved solely to the policyholder.

(b) All riders or endorsements added to an individual long term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured, except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long term care insurance policy. After the date of policy issue, any rider or endorsement which increases benefits or coverage which also increases the premium during the policy term must be accepted to in writing signed by the insured, except if the increased benefits or coverage are required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider, or endorsement.

(c) A long term care insurance policy or certificate which provides for the payment of benefits based on standards described as “usual and customary”, “reasonable and customary”, or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(d) If a long term care insurance policy, certificate, or subscriber agreement contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy, certificate, or subscriber agreement and shall be labeled as “Preexisting Condition Limitations”.

(e) A long term care insurance policy, certificate, or subscriber agreement containing any limitations or conditions for eligibility other than those prohibited in IC 27-8-12-10.6 shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy, certificate, or subscriber agreement and shall label such paragraph “Limitations or Conditions on Eligibility for Benefits”.

(f) Life insurance policies which provide an accelerated benefit for long term care are required to include a disclosure statement:

(1) at the time of application for the policy or rider; and

(2) at the time the accelerated benefit payment request is submitted;

that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. *(Department of Insurance; 760 IAC 2-4-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 860; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 5. Prohibition Against Post-Claims Underwriting

760 IAC 2-5-1 Application; medication

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) All applications for long term care insurance policies, certificates, or subscriber agreements except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(b) If an application for long term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(c) If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy, certificate, or subscriber agreement shall not be rescinded for that condition. *(Department of Insurance; 760 IAC 2-5-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 860; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-5-2 Language of application; supplemental information

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. Except for policies, certificates, or subscriber agreements which are guaranteed issue, the following apply:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long term care insurance policy, certificate, or subscriber agreement: "Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your [policy] [certificate] [subscriber agreement].".

(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the long term care insurance policy, certificate, or subscriber agreement at the time of delivery: "Caution: The issuance of this long term care insurance [policy] [certificate] [subscriber agreement] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your [policy] [certificate] [subscriber agreement]. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address].".

(3) Prior to issuance of a policy, certificate, or subscriber agreement to an applicant eighty (80) years of age or older, the insurer shall obtain one (1) of the following:

(A) A report of a physical examination.
(B) An assessment of functional capacity.
(C) An attending physician's statement.
(D) Copies of medical records.

(Department of Insurance; 760 IAC 2-5-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 860; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-5-3 Completed application or enrollment form

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy, certificate, or subscriber agreement unless it was retained by the applicant at the time of application. *(Department of Insurance; 760 IAC 2-5-3; filed Oct 30, 1992, 12:00 p.m.: 16 IR 861; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-5-4 Records

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 4. Every insurer or other entity selling or issuing long term care insurance benefits shall maintain a record of all policy, certificate, or subscriber agreement rescissions, both statewide and country wide, except those which the insured voluntarily effectuated and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners. *(Department of Insurance; 760 IAC 2-5-4; filed Oct 30, 1992, 12:00 p.m.: 16 IR 861; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 6. Home Health Care Benefits in Long Term Care Insurance Policies

760 IAC 2-6-1 Minimum standards for home health and community care benefits

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) A long term care insurance policy, certificate, or subscriber agreement shall not, if it provides benefits for home health and community care services, limit or exclude benefits as follows:

(1) By requiring that the insured/claimant need skilled care in a skilled nursing facility if home health care services were not provided.

(2) By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home, community, or institutional setting before home health care services are covered.

(3) By limiting eligible services to services provided by registered nurses or licensed practical nurses.

(4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification.

(5) By requiring that the insured/claimant have an acute condition before home health care services are covered.

(6) By limiting benefits to services provided by Medicare-certified agencies or providers.

(7) By excluding coverage for personal care services provided by a home health aide.

(8) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service.

(9) By excluding coverage for adult day care services.

(b) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy, certificate, or subscriber agreement.

(c) A long term care insurance policy, certificate, or subscriber agreement, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of one (1) year's coverage available for nursing home benefits under the policy, certificate, or subscriber agreement, at the time covered home health or community care services are being received. This requirement shall not apply to policies, certificates, or subscriber agreements issued to residents of continuing care retirement communities. *(Department of Insurance; 760 IAC 2-6-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 861; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 7. Inflation Protection Offer

760 IAC 2-7-1 General provisions

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature. An inflation protection feature shall provide at least one (1) of the following:

(1) Increase benefit levels annually to be compounded annually at a rate not less than five percent (5%).

(2) Guarantee the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be more than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.

(3) Cover a specified percentage of actual or reasonable charges and do not include a maximum specified indemnity amount or limit.

(b) Inflation protection benefit increases under a policy which contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(c) An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium, which the insurer expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(d) Inflation protection as provided in subsection (a) shall be included in a long term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder. The rejection shall be considered a part of the application and shall state: “I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection and I reject inflation protection.

(Signature of Applicant(s))".
(Department of Insurance; 760 IAC 2-7-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-7-2 Group policy; exception
Authority: IC 27-8-12-7
Affected: IC 27-8-5-17; IC 27-8-12

Sec. 2. Where the policy is issued to a group, the required offer under section 1 of this rule shall be made to the group policyholder; except, if the policy is issued to a group defined in IC 27-8-5-17 other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder. *(Department of Insurance; 760 IAC 2-7-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-7-3 Accelerated long term care benefits
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3. The offer under section 1 of this rule shall not be required of life insurance policies or riders containing accelerated long term care benefits. *(Department of Insurance; 760 IAC 2-7-3; filed Oct 30, 1992, 12:00 p.m.: 16 IR 862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-7-4 Outline of coverage
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 4. Insurers shall include the following information in or with the outline of coverage:
(1) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.
(2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at seventy-five (75) and eighty-five (85) years of age for benefit increases.
(3) An insurer may use a reasonable hypothetical or a graphic demonstration, for the purposes of this disclosure.
(Department of Insurance; 760 IAC 2-7-4; filed Oct 30, 1992, 12:00 p.m.: 16 IR 862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 8. Application Forms and Replacement Coverage

760 IAC 2-8-1 Questions
Authority: IC 27-8-12-7
Affected: IC 27-8-5-16; IC 27-8-12

Sec. 1. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long term care insurance policy, certificate, or subscriber agreement in force or whether a long term care policy, certificate, or subscriber agreement is intended to replace any other accident and sickness or long term care policy, certificate, or subscriber agreement presently in force:
(1) Do you have another long term care insurance policy or certificate in force (including health care service contract, or health maintenance organization contract)?
(2) Did you have another long term care insurance policy or certificate in force during the last twelve (12) months? If so:
(A) with which company; and

(B) if that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid?

(4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to a group defined by IC 27-8-5-16(1), the questions in this section may be modified only to the extent necessary to elicit information about health or long term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement. *(Department of Insurance; 760 IAC 2-8-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-8-2 Any other health insurance policies

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. (a) Agents shall list any other health insurance policies they have sold to the applicant.

(b) Agents shall list policies sold which are still in force.

(c) Agents shall list policies sold in the past five (5) years which are no longer in force. *(Department of Insurance; 760 IAC 2-8-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 863; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-8-3 Notice regarding replacement of accident and sickness or long term care insurance

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent, shall furnish the applicant, prior to issuance or delivery of the long term care insurance policy, a notice regarding replacement of accident and sickness or long term care coverage. One (1) copy of such notice shall be retained by the applicant, and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING
REPLACEMENT OF ACCIDENT AND SICKNESS
OR LONG TERM CARE INSURANCE
[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT
TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with a long term care insurance policy to be issued by [company name]. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]: (Use additional sheets, as necessary.) I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present coverage.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy

(or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____
(Signature of Agent, Broker or Other Representative)

_____
[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

(Department of Insurance; 760 IAC 2-8-3; filed Oct 30, 1992, 12:00 p.m.: 16 IR 863; errata filed Jan 19, 1993, 10:00 a.m.: 16 IR 1514; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-8-4 Direct response solicitations

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 4. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long term care coverage to the applicant upon issuance of the policy, certificate, or subscriber agreement. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING
REPLACEMENT OF ACCIDENT AND SICKNESS
OR LONG TERM CARE INSURANCE
[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT
TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with the long term care insurance [policy] [certificate] [subscriber agreement] delivered herewith issued by [company name]. Your new [policy] [certificate] [subscriber agreement] provides thirty (30) days within which you may decide, without cost, whether you desire to keep the [policy] [certificate] [subscriber agreement]. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new [policy] [certificate] [subscriber agreement].

You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer

or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

(Department of Insurance; 760 IAC 2-8-4; filed Oct 30, 1992, 12:00 p.m.: 16 IR 864; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-8-5 Replacement; notification

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 5. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy, certificate, or subscriber agreement shall be identified by the insurer, name of the insured, and policy number or address including zip code. Such notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy, certificate, or subscriber agreement is issued, whichever is sooner. *(Department of Insurance; 760 IAC 2-8-5; filed Oct 30, 1992, 12:00 p.m.: 16 IR 864; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 9. Reporting Requirements

760 IAC 2-9-1 Reporting

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long term care insurance policies sold by the agent as a percent of the agent's total annual sales.

(b) Each insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by subsection (a).

(c) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long term care insurance.

(d) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(e) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

(f) For purposes of this rule, “policy” means only long term care insurance and “report” means on a statewide basis. *(Department of Insurance; 760 IAC 2-9-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 865; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 10. Licensing

760 IAC 2-10-1 Licensing

Authority: IC 27-8-12-7
Affected: IC 27-1-15.5-3; IC 27-1-15.5-7.1

Sec. 1. (a) No agent is authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing long term care insurance until the agent has successfully passed eight (8) hours of approved continuing education courses in long term

care and long term care insurance. An agent who completes the eight (8) hours of continuing education required by this subsection during the first two (2) years of a four (4) year license shall also comply with subsection (b) during the second two (2) years of the license.

(b) An agent shall successfully complete five (5) hours of approved continuing education in long term care or long term care insurance every two (2) years for a total of ten (10) hours in every four (4) year license renewal period.

(c) Continuing education courses completed pursuant to subsections (a) and (b) may be used to satisfy the continuing education requirements set forth in IC 27-1-15.5-7.1.

(d) Each insurer shall require an agent to provide documentation certifying that the agent has satisfied the requirements of this rule prior to accepting applications from the agent or paying the agent commission for the sale of long term care coverage. *(Department of Insurance; 760 IAC 2-10-1; filed Oct. 30, 1992, 12:00 p.m.: 16 IR 865; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 2, 2001, 4:50 p.m.: 25 IR 382)*

Rule 11. Discretionary Powers of Commissioner

760 IAC 2-11-1 Modification or suspension

Authority: IC 27-8-12-7
Affected: IC 4-21.5; IC 27-8-12

Sec. 1. The commissioner may, upon written request and after a hearing under IC 4-21.5, issue an order to modify or suspend a specific provision or provisions of this article with respect to a specific long term care insurance policy, certificate, or subscriber agreement upon a written finding of the following:

(1) The modification or suspension would be in the best interest of the insureds.

(2) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension.

(3) Any of the following are necessary:

(A) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long term care.

(B) The policy, certificate, or subscriber agreement is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community.

(C) The modification or suspension is necessary to permit long term care insurance to be sold as part of, or in conjunction with, another insurance product.

(Department of Insurance; 760 IAC 2-11-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 865; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 12. Reserve Standards

760 IAC 2-12-1 Reserves for policies, certificates, and riders

Authority: IC 27-8-12-7
Affected: IC 27-1-12-10; IC 27-8-12

Sec. 1. (a) When long term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies or certificates, policy reserves for such benefits shall be determined in accordance with IC 27-1-12-10(2)(h). Claim reserves must also be established in the case when such policy, certificate, or rider is in claim status. Reserves for policies, certificates, and riders subject to this section should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long term care benefits. However, in no event shall the reserves for the long term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long term care benefit.

(b) In the development and calculation of reserves for policies, certificates, and riders subject to this section, due regard shall

be given to the applicable policy, certificate, or rider provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

(1) Definition of insured events.
(2) Covered long term care facilities.
(3) Existence of home convalescence care coverage.
(4) Definition of facilities.
(5) Existence or absence of barriers to eligibility.
(6) Premium waiver provision.
(7) Renewability.
(8) Ability to raise premiums.
(9) Marketing method.
(10) Underwriting procedures.
(11) Claims adjustment procedures.
(12) Waiting period.
(13) Maximum benefit.
(14) Availability of eligible facilities.
(15) Margins in claim costs.
(16) Optional nature of benefit.
(17) Delay in eligibility for benefit.
(18) Inflation protection provisions.
(19) Guaranteed insurability option.

(c) Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

(d) When long term care benefits are provided other than as in subsections (a) and (b), reserves shall be determined using a table established for reserve purposes by a qualified actuary and acceptable to the commissioner. *(Department of Insurance; 760 IAC 2-12-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 865; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 13. Loss Ratio

760 IAC 2-13-1 Relevant factors

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. Benefits under individual long term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including the following:

(1) Statistical credibility of incurred claims experience and earned premiums.
(2) The period for which rates are computed to provide coverage.
(3) Experienced and projected trends.
(4) Concentration of experience within early policy duration.
(5) Expected claim fluctuation.
(6) Experience refunds, adjustments, or dividends.
(7) Renewability features.
(8) All appropriate expense factors.
(9) Interest.
(10) Experimental nature of the coverage.
(11) Policy reserves.
(12) Mix of business by risk classification.
(13) Product features such as long elimination periods, high deductibles, and high maximum limits.

(Department of Insurance; 760 IAC 2-13-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 866; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 14. Filing Requirements

760 IAC 2-14-1 Approval by commissioner

Authority: IC 27-8-12-7
Affected: IC 27-8-12-17

Sec. 1. (a) Prior to an insurer or similar organization offering group long term care insurance to a resident of this state under IC 27-8-12-17, it shall file for approval with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long term care insurance requirements substantially similar to those adopted in this state.

(b) The commissioner shall review the policy or certificate to determine whether the policy or certificate complies with the requirements of this rule. *(Department of Insurance; 760 IAC 2-14-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 866; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-14-2 Advertising

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. (a) Every insurer, health care service plan, or other entity providing long term care insurance or benefits in Indiana shall provide a copy of any long term care insurance advertisement intended for use in Indiana whether through written, radio, or television medium to the commissioner of insurance of this state for review and approval by the commissioner. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity for at least three (3) years from the date the advertisement was first used.

(b) The commissioner may exempt from subsection (a) any advertising form or material when, in the commissioner's opinion, subsection (a) may not be reasonably applied. *(Department of Insurance; 760 IAC 2-14-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 15. Marketing

760 IAC 2-15-1 Standards

Authority: IC 27-8-12-7
Affected: IC 27-4-1-4; IC 27-8-12

Sec. 1. (a) Every insurer, health care service plan, or other entity marketing long term care insurance coverage in this state, directly or through its producers, shall do the following:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy, certificate, or subscriber agreement the following: “Notice to buyer: This [policy] [certificate] [subscriber agreement] may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all [policy] [certificate] [subscriber agreement] limitations.”.

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long term care insurance already has accident and sickness or long term care insurance and the types and amounts of any such insurance.

(5) Every insurer or entity marketing long term care insurance shall establish auditable procedures for verifying compliance with this subsection.

(b) In addition to the practices prohibited in IC 27-4-1-4, the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies, coverage, or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or coverage or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(Department of Insurance; 760 IAC 2-15-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 16. Purchase or Replacement

760 IAC 2-16-1 Appropriateness of recommended purchase

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. In recommending the purchase or replacement of any long term care insurance policy, certificate, or subscriber agreement, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement. *(Department of Insurance; 760 IAC 2-16-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-16-2 Prohibition against preexisting conditions and probationary periods in replacement policies or certificates

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. If a long term care insurance policy, certificate, or subscriber agreement replaces another long term care policy, certificate, or subscriber agreement, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long term care policy, certificate, or subscriber agreement for similar benefits to the extent that similar exclusions have been satisfied under the original policy, certificate, or subscriber agreement. *(Department of Insurance; 760 IAC 2-16-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 17. Outline of Coverage

760 IAC 2-17-1 Standard

Authority: IC 27-8-12-7; IC 27-8-12-14
Affected: IC 27-8-12

Sec. 1. (a) The outline of coverage shall be a free-standing document, using no smaller than ten (10) point type.

(b) The outline of coverage shall contain no material of an advertising nature.

(c) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

(d) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(e) The format for the outline of coverage shall be as follows:

[COMPANY NAME]
[ADDRESS – CITY AND STATE]

[TELEPHONE NUMBER]
LONG TERM CARE INSURANCE
OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies, certificates, or subscriber agreements which are guaranteed issue, the following caution statement, or language substantially similar, must appear in the outline of coverage.]

Caution: The issuance of this long term care insurance [policy] [certificate] [subscriber agreement] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

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

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return – "free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government, or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government, or any state government.

5. LONG TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one (1) or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home. This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

6. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductible(s), waiting periods, elimination periods, and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Noninstitutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long term care, then these qualifying criteria or screens must be explained.]

7. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions.

(b) Noneligible facilities/provider.

(c) Noneligible levels of care, e.g., unlicensed providers, care or treatment provided by a family member, etc.

(d) Exclusions/exceptions.

(e) Limitations.]

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

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

8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time.

(b) Any automatic benefit adjustment provisions.

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage.

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations.

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

[(a) Describe the policy renewability provisions.

(b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.

(c) Describe waiver of premium provisions or state that there are not such provisions.

(d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

11. PREMIUM.

[(a) State the total annual premium for the policy.

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

12. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used.

(b) Describe other important features.]

(Department of Insurance; 760 IAC 2-17-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 868; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 18. Shopper's Guide

760 IAC 2-18-1 Delivery

Authority: IC 27-8-12-7
Affected: IC 27-8-12-14.5

Sec. 1. (a) A long term care insurance shopper's guide in a format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long term care insurance policy or certificate. Delivery shall be as follows:

(1) In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(2) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

(b) Life insurance policies or riders containing accelerated long term care benefits are not required to furnish the guide referenced in subsection (a), but shall furnish the policy summary required under IC 27-8-12-14.5. *(Department of Insurance; 760 IAC 2-18-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 869; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 19. Penalties

760 IAC 2-19-1 Civil penalties

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. In addition to any other penalties provided by the laws or rules of this state, the commissioner may impose a civil penalty against an insurer which has violated the laws or rules. A penalty imposed under this section shall be the greater of:

(1) three (3) times the amount of the commissions paid for each policy involved in the violation; or

(2) ten thousand dollars ($10,000).

(Department of Insurance; 760 IAC 2-19-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 869; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-19-2 Other sanctions

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. In addition to any other sanction provided under the laws or rules of this state, the commissioner may impose a penalty against the insurance agent who has violated the laws or rules. The penalty shall be the greater of:

(1) three (3) times the amount of the commissions paid for each policy involved in the violation; or

(2) two thousand five hundred dollars ($2,500).

(Department of Insurance; 760 IAC 2-19-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 870; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 20. Indiana Long Term Care Program

760 IAC 2-20-1 Authority

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 1. This rule is adopted and promulgated by the department of insurance under IC 27-8-12-7.1. *(Department of Insurance; 760 IAC 2-20-1; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1145; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-2 Purpose

Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2

Sec. 2. The purpose of this rule is to:

(1) establish minimum standards for long term care insurance policies, certificates, and riders to qualify for participation in the Indiana long term care program;

(2) establish documentation and reporting requirements for issuers of policies, certificates, or riders to qualify under the Indiana long term care program;

(3) provide full disclosures in the sale of long term care insurance policies, certificates, and riders which qualify under the Indiana long term care program; and

(4) facilitate public understanding regarding long term care insurance and long term care insurance policies, certificates, and riders which qualify under the Indiana long term care program.

(Department of Insurance; 760 IAC 2-20-2; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1145; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2644; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-3 Applicability

Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2

Sec. 3. The requirements of this rule apply to any long term care insurance policy, certificate, or rider authorized for sale by the commissioner of the department of insurance as qualifying under the Indiana long term care program under IC 27-8-12-7.1.
(Department of Insurance; 760 IAC 2-20-3; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1145; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2644; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-4 "Activities of daily living" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 4. (a) As used in this rule, "activities of daily living" include each of the following items:
(1) Eating.
(2) Transferring.
(3) Dressing.
(4) Bathing.
(5) Toileting or continence.
(b) The following definitions apply throughout this section:
(1) "Eating" means feeding oneself by getting food into the body from a receptacle, feeding tube, or intravenously.
(2) "Transferring" means moving into or out of a bed, chair, or wheelchair.
(3) "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
(4) "Bathing" means washing oneself by sponge bath in a tub or shower, including the task of getting into or out of the tub or shower.
(5) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
(6) "Continence" means the ability to maintain control of bowel and bladder function or when unable to maintain control of bowel or bladder function the ability to perform associated personal hygiene, including care for catheter or colostomy bag.
(Department of Insurance; 760 IAC 2-20-4; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1145; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-5 "Asset disregard" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 5. As used in this rule, "asset disregard" means the total equity value of personal property, assets, and resources not exempt under Medicaid regulations which at a minimum are equal to the sum of qualifying insurance benefit payments made on behalf of the qualified insured in determining eligibility for the Medicaid program under IC 12-15-2. The following are the two (2) types of asset disregard:
(1) "Dollar-for-dollar asset disregard" means the amount of the disregard is equal to the sum of qualifying insurance benefit payments made on behalf of the qualified insured.
(2) "Total asset disregard" means the amount of the disregard is equal to the total sum of assets owned by the qualified insured once the qualified insured has exhausted all qualifying insurance benefits.
(Department of Insurance; 760 IAC 2-20-5; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1145; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2644; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-6 "Asset protection" defined
Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 6. As used in this rule, "asset protection" means the right extended by IC 12-15-39.6 to beneficiaries of qualified long term care insurance policies and certificates to an asset disregard under the Indiana long term care program. *(Department of Insurance; 760 IAC 2-20-6; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-7 "Authorized designee" defined
Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 7. As used in this rule, "authorized designee" means any person designated in writing to the insurance company by the policyholder or certificateholder of a qualified long term care policy or certificate for purposes of notification under section 36(8) of this rule. *(Department of Insurance; 760 IAC 2-20-7; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-8 "Average daily private pay rate" defined
Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 8. As used in this rule, "average daily private pay rate" means the average daily rate charged by nursing facilities for persons not qualifying for federal or state reimbursement, established annually on a calendar year basis by OMPP for the period immediately preceding the effective date or renewal date of a policy or certificate. *(Department of Insurance; 760 IAC 2-20-8; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-9 "Case management" defined
Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 9. As used in this rule, "case management" includes, but is not limited to, the development of a comprehensive individualized assessment and care plan and, as needed, coordination of appropriate services and the monitoring of the delivery of such services. *(Department of Insurance; 760 IAC 2-20-9; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-10 "Case management agency" defined
Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 10. As used in this rule, "case management agency" means an agency or other entity approved by DDARS as meeting DDARS case management standards contained in the DDARS community and home care services provider manual. *(Department of Insurance; 760 IAC 2-20-10; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-11 "Certificate" defined
Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 11. As used in this rule, "certificate" means any certificate delivered or issued for delivery in this state under a group long

term care policy. *(Department of Insurance; 760 IAC 2-20-11; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-12 "Certificate form" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 12. As used in this rule, "certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer. *(Department of Insurance; 760 IAC 2-20-12; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-13 "Certificateholder" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 13. As used in this rule, "certificateholder" means an owner of a qualified long term care insurance certificate or the beneficiary of a qualified long term care certificate. *(Department of Insurance; 760 IAC 2-20-13; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-14 "Cognitive impairment" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 14. As used in this rule, "cognitive impairment" means confusion or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to or a result of mental illness but which can result from Alzheimer's disease or similar forms of senility or irreversible dementia. This deterioration or loss of intellectual capacity is established through use of standardized tests that reliably measure impairment in the following areas:

(1) Short term or long term memory.
(2) Orientation as to person, place, and time.
(3) Deductive or abstract reasoning.

Cognitive impairment must result in an individual requiring twenty-four (24) hour a day supervision or direct assistance to maintain his or her safety. *(Department of Insurance; 760 IAC 2-20-14; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-15 "Complex, unstable medical condition" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 15. As used in this rule, "complex, unstable medical condition" means that the individual requires twenty-four (24) hour a day professional nursing observation or professional nursing intervention more than once a day in a setting other than an acute care wing of a hospital. *(Department of Insurance; 760 IAC 2-20-15; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-16 "DDARS" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 16. As used in this rule, "DDARS" means the Indiana division of disability, aging, and rehabilitative services. *(Department of Insurance; 760 IAC 2-20-16; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-17 "Deficiency in activities of daily living" defined (Repealed)

Sec. 17. *(Repealed by Department of Insurance; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001)*

760 IAC 2-20-18 "Direct assistance" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 18. As used in this rule, "direct assistance" means that the individual cannot perform an activity of daily living safely or appropriately without continual help or oversight. Direct assistance may vary from requiring a person to physically stand by or set up the activity to the activity being totally performed by others. *(Department of Insurance; 760 IAC 2-20-18; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-18.1 "Eligible long term care services" defined (Repealed)

Sec. 18.1. *(Repealed by Department of Insurance; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001)*

760 IAC 2-20-19 "Indiana long term care program" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 19. As used in this rule, the "Indiana long term care program" means the program authorized in IC 27-8-12-7.1 and IC 12-15-39.6. *(Department of Insurance; 760 IAC 2-20-19; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-20 "Indiana preadmission screening program" defined (Repealed)

Sec. 20. *(Repealed by Department of Insurance; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001)*

760 IAC 2-20-21 "Insured event" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 21. (a) Except as specified in subsection (b), as used in this rule, "insured event" means, for the purposes of determining eligibility for benefits under a qualified policy, or certificate, or rider and for determining whether these benefits result in an asset disregard for a qualified insured, that any one (1) of the following criteria is met:

(1) The individual has a deficiency in two (2) or more activities of daily living.

(2) The individual has a cognitive impairment.

(3) The individual has a complex, unstable medical condition.

(b) For qualified policies eligible for favorable tax status, "insured event" means when the policyholder has become a "chronically ill individual" as that term is defined in the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, Sections 321 through 327, hereinafter referred to as "HIPAA 1996". When determining the loss of functional capacity, the policyholder must be unable to perform (without substantial assistance from another individual) two (2) or more of six (6) activities of daily living (as set forth in HIPAA 1996) for a period of at least ninety (90) days. *(Department of Insurance; 760 IAC 2-20-21; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2644; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3369; errata, 21 IR 111; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-21.1 "Integrated policy" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2

Sec. 21.1. As used in this rule, "integrated policy" refers to any qualified long term care insurance policy or certificate which provides coverage for both long term care facilities and home and community care services. *(Department of Insurance; 760 IAC 2-20-21.1; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2645; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-22 "Issuer" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 22. As used in this rule, "issuer" means:
(1) insurance companies;
(2) fraternal benefit societies;
(3) prepaid health care delivery plans;
(4) health care service plans;
(5) health maintenance organizations; and
(6) any other entity;
delivering or issuing for delivery in this state, long term care policies or certificates. *(Department of Insurance; 760 IAC 2-20-22; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-22.1 "Long term care facility" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2; IC 16-28

Sec. 22.1. As used in this rule, "long term care facility" means a facility licensed under IC 16-28, including nursing facilities and residential care facilities. *(Department of Insurance; 760 IAC 2-20-22.1; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2645; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-22.2 "Long term care facility policy" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 22.2. As used in this rule, "long term care facility policy" refers to any qualified long term care insurance policy or certificate which provides coverage primarily for care in a long term care facility and does not provide coverage for home and community care. *(Department of Insurance; 760 IAC 2-20-22.2; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2645; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1990; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-23 "Medicaid eligible long term care services" defined (Repealed)

Sec. 23. *(Repealed by Department of Insurance; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2653)*

760 IAC 2-20-24 "Medicaid waiver" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 24. As used in this rule, "Medicaid waiver" refers to the home and community based services waiver for the aged and disabled approved by the United States Department of Health and Human Services Health Care Financing Administration under the provisions of Section 1915(c) of the Social Security Act which allows Indiana to provide certain community and in-home services not covered in the state Medicaid plan, which are instrumental in the avoidance or delay of institutionalization. Indiana's Medicaid waiver services include:
(1) case management;
(2) homemaker;

(3) respite care;
(4) attendant care;
(5) adult day care; and
(6) other services which, independent of the preceding home and community based services, are essential to prevent institutionalization.

(Department of Insurance; 760 IAC 2-20-24; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-24.1 "Minimum inflation adjusted daily benefit" defined (Repealed)

Sec. 24.1. *(Repealed by Department of Insurance; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001)*

760 IAC 2-20-25 "OMPP" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 25. As used in this rule, "OMPP" means the Indiana office of medicaid policy and planning. *(Department of Insurance; 760 IAC 2-20-25; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-26 "Plan of care" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 26. As used in this rule, "plan of care" means a written individualized plan of services developed by a case management agency which specifies the type and frequency of all services required by the individual, the service providers, and the cost of services. *(Department of Insurance; 760 IAC 2-20-26; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1990; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-26.5 "Policy eligible for favorable tax status" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 27-8-12-7

Sec. 26.5. As used in this rule, "policy eligible for favorable tax status" means any long term care insurance policy or certificate meeting federal standards of HIPAA 1996, including clearly disclosing in the policy and in the outline of coverage that such policy is intended to be a long term care insurance contract eligible for favorable tax status under Section 7702B(b) of Chapter 79 of the Internal Revenue Code of 1986. *(Department of Insurance; 760 IAC 2-20-26.5; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3370; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-27 "Policy form" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 27. As used in this rule, "policy form" means the form on which the policy is delivered or issued for delivery by the issuer. *(Department of Insurance; 760 IAC 2-20-27; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-28 "Policyholder" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 28. As used in this rule, "policyholder" means an owner of an individual qualified long term care insurance policy or a beneficiary of a qualified individual long term care insurance policy. *(Department of Insurance; 760 IAC 2-20-28; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-29 "Qualified insured" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2

Sec. 29. As used in this rule, "qualified insured" means the following:

(1) An individual who is either:

(A) the beneficiary of a qualified long term care policy, certificate, or rider approved by the department of insurance; or

(B) enrolled in a prepaid health care delivery plan that provides long term care services and qualifies under this rule.

(2) An individual who is eligible for an asset disregard under a qualified long term care policy, certificate, or rider.

(Department of Insurance; 760 IAC 2-20-29; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2645; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-30 "Qualified long term care insurance policy or certificate" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6; IC 27-8-12-7

Sec. 30. As used in this rule, "qualified long term care insurance policy or certificate" means:

(1) any long term care insurance policy or certificate qualified for sale to Indiana residents by the department of insurance as meeting standards promulgated under IC 27-8-12-7 and IC 27-8-12-7.1; or

(2) any long term care insurance policy or certificate owned by an Indiana resident purchased under another state's Partnership for Long Term Care Program if the other state's program is similar to the Indiana Long Term Care Program and OMPP has a reciprocity agreement with the other state's Medicaid program.

(Department of Insurance; 760 IAC 2-20-30; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1149; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1990; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-30.1 "Qualified rider" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 27-8-12-7

Sec. 30.1. As used in this rule, "qualified rider" means any long term care insurance rider qualified for sale to Indiana residents by the department of insurance as meeting standards promulgated under IC 27-8-12-7 and IC 27-8-12-7.1. *(Department of Insurance; 760 IAC 2-20-30.1; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2645; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3370; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-31 "Quarterly/annually" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 31. As used in this rule, "quarterly/annually" refers to periods aligning with the state fiscal year of July 1 to June 30. *(Department of Insurance; 760 IAC 2-20-31; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1149; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-31.1 "Residential care facility" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2; IC 16-28

Sec. 31.1. As used in this rule, "residential care facility", also referred to as assisted living facility and alternate care facility, means a facility licensed under IC 16-28 and 410 IAC 16.2-5 which:

(1) provides twenty-four (24) hour a day care and services sufficient to support needs resulting from inability to perform activities of daily living or cognitive impairment;

(2) has a trained and ready to respond employee on duty in the facility at all times to provide care;

(3) provides three (3) meals a day and accommodates special dietary needs;

(4) has written contractual arrangements or otherwise ensures that residents receive the medical care services of a physician or nurse in case of emergency; and

(5) has appropriate methods and procedures for the handling and administration of prescribed medications and treatments.

(Department of Insurance; 760 IAC 2-20-31.1; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2646; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-32 "Service summary" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 32. As used in this rule, "service summary" means a written summary, prepared by an issuer for a qualified insured, which identifies the following:

(1) The specific qualified policy or certificate.

(2) The total benefits paid for services to date.

(3) The amount of benefits qualifying for asset protection.

(Department of Insurance; 760 IAC 2-20-32; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1149; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-32.5 State-set dollar amount

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 32.5. As used in this rule, "state-set dollar amount" means the least amount of maximum benefit a policyholder or certificateholder must initially purchase in a qualified policy or certificate to be eligible for a total asset disregard. The state-set dollar amount begins at one hundred forty thousand dollars ($140,000) for qualified policies with an effective date of 1998 or earlier. The state-set dollar amount will increase each year on January 1 by five percent (5%) compounded annually, rounded to the nearest one dollar ($1) increment, and applies to new policies effective during each calendar year. *(Department of Insurance; 760 IAC 2-20-32.5; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1990; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-33 Qualification of long term care insurance policies, certificates, and riders

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 33. (a) No long term care insurance policy, or certificate, or rider shall qualify for participation in the Indiana long term care program unless the long term care insurance policy, or certificate, or rider complies with this rule.

(b) The commissioner of the department of insurance may not approve a long term care facility policy or certificate as a qualified policy or certificate for participation in the Indiana long term care program unless the issuer has an approved qualified integrated policy or certificate.

(c) The commissioner of the department of insurance may not approve a long term care facility policy or certificate eligible for favorable tax status as a qualified policy or certificate for participation in the Indiana long term care program unless the issuer has an approved qualified integrated policy or certificate eligible for favorable tax status.

(d) Long term care insurance policies, and certificates, and riders in force at the effective date of this rule may, with the signed acceptance of the policyholder or certificateholder, be amended to meet the requirements for qualification. *(Department of Insurance; 760 IAC 2-20-33; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1149; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2646; filed Jul 28,*

1997, 1:50 p.m.: 20 IR 3370; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-34 Standards for marketing

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6; IC 27-1-15.5-7.1; IC 27-1-15.5-7.3

Sec. 34. No long term care insurance policy, or certificate, or rider may be advertised, solicited, or issued for delivery in this state as a qualified long term care insurance policy, or certificate, or rider which does not meet the requirements of this article and has not been approved by the commissioner of the department of insurance as a qualified long term care insurance policy, or certificate, or rider. Each issuer seeking to qualify a long term care policy, or certificate, or rider for participation in the Indiana long term care program must do the following:

(1) Use applications to be signed by the applicant which indicate, as described as follows, that he or she:

(A) Received from the issuer the current edition of a booklet developed by OMPP titled "What you should know about long term care: The most commonly asked questions about the Indiana Long Term Care Program".

(B) Received a description of the issuer's qualified long term care policy or certificate benefit option meeting the requirements of sections 36.1(2) and 36.2(2) of this rule.

(C) Agrees to the release of information by the issuer to the state as may be needed to evaluate the Indiana long term care program and document a claim for Medicaid asset protection, in the following format:

"CONSENT AND AUTHORIZATION
TO RELEASE INFORMATION

I hereby agree to the release of all records and information pertaining to this long term care policy or certificate by the [insert issuer name] to the State of Indiana for the purposes of documenting a claim for Asset Protection under the State Medicaid program, evaluating the Indiana Long Term Care Program, and meeting Medicaid or Department of Insurance audit requirements.

I understand that the information contained in these records will be used for no purpose other than those stated above, and will be kept strictly confidential by the State of Indiana.

_____ _____
(Signature of Applicant(s)) Date".

(D) Received a graphic comparison showing the differences in premiums and benefits, over at least a twenty (20) year period, between a policy or certificate that increases benefits over the policy or certificate period and a policy or certificate that does not increase benefits.

(2) Obtain a signed statement from all applicants for a qualifying long term care facility policy or certificate indicating that they have been offered a qualifying integrated policy or certificate and declined this option. This statement shall be considered part of the application and shall state the following:

"I have been offered a policy or certificate qualifying under the Indiana Long Term Care Program which provides coverage for both nursing home and home and community care services, and I decline the offer to apply for this coverage.

I understand that in the event I later want to purchase qualifying home and community care benefits through a qualifying rider, I may be required to furnish evidence of insurability and the insurer will have the right to refuse my request.

I also understand that the cost of purchasing home and community care benefits at a later date will be more expensive, since the premium for these benefits will be based upon my age at the time of such purchase.

_____ _____
Date Signature of Applicant".

(3) Provide to the applicant the option of having the application date of the policy being issued as the effective date. Where the policy is issued to a group and the group designates a day other than the application date as the effective date, any applicant for a certificate of coverage in an amount that meets or exceeds the state-set dollar amount at the time of application will be issued a certificate with coverage equal to the greater of the following:

(A) The certificate value applied for. or

(B) The state-set dollar amount in force on the certificate's effective date. In the event the value increases as a result

of this provision, the premium may be adjusted accordingly. An election to choose the lesser value in a certificate shall be supported by a statement signed by the applicant that clearly discloses the certificate will earn dollar-for-dollar asset protection.

(4) Provide to the policyholder or certificateholder upon delivery of a qualified long term care insurance policy or certificate a complete description of the asset protection options under the Indiana long term care program and a description of Medicaid in a format prescribed by OMPP.

(5) Report to the commissioner of the department of insurance all sales involving replacement of existing policies and certificates by qualified policies or certificates within thirty (30) days of the issue date of the newly issued qualified policy or certificate. The report shall include the following:

(A) The name and address of the insured.

(B) The name of the company whose policy or certificate is being replaced.

(C) The name of the agent replacing the coverage.

This report shall also include a comparison of the coverage issued with that being replaced, including a comparison of premiums and an explanation of how the replacement was beneficial to the insured. The replacing issuer shall not cancel, nonrenew, or rescind a replacement policy or certificate for any reason other than nonpayment of premium, material misrepresentation, or fraud.

(6) Provide written evidence to the department of insurance that procedures are in place to assure that no agent or telemarketer will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a qualified long term care insurance policy or certificate unless the agent or telemarketer has completed fifteen (15) hours of continuing education training on long term care insurance, consisting of eight (8) hours in general long term care and seven (7) hours on the Indiana long term care program specifically.

(7) Include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows:

THIS POLICY [CERTIFICATE] QUALIFIES UNDER THE INDIANA LONG TERM CARE INSURANCE PROGRAM FOR MEDICAID ASSET PROTECTION. THIS POLICY [CERTIFICATE] MAY PROVIDE BENEFITS IN EXCESS OF THE ASSET PROTECTION PROVIDED IN THE INDIANA LONG TERM CARE PROGRAM.

(8) For all long term care facility policies or certificates, include a statement on the outline of coverage and the front page of the policy or certificate in bold type and prominently displayed which states: LONG TERM CARE FACILITY POLICY [CERTIFICATE].

(9) Include a statement on the qualified rider in bold type and in a separate box as follows:

THIS RIDER QUALIFIES UNDER THE INDIANA LONG TERM CARE PROGRAM FOR MEDICAID ASSET PROTECTION WHEN ATTACHED TO A LONG TERM CARE POLICY WHICH ALSO QUALIFIES FOR MEDICAID ASSET PROTECTION. THIS RIDER MAY PROVIDE BENEFITS IN EXCESS OF THE ASSET PROTECTION PROVIDED IN THE INDIANA LONG TERM CARE PROGRAM.

(10) Long term care insurance policies or certificates sold after April 1, 1993, that are not qualified under the Indiana long term care program must include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows:

THIS POLICY [CERTIFICATE] DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE INDIANA LONG TERM CARE PROGRAM. HOWEVER, THIS POLICY [CERTIFICATE] IS AN APPROVED LONG TERM CARE INSURANCE POLICY [CERTIFICATE] UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE INDIANA LONG TERM CARE PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DEPARTMENT OF INSURANCE AT 1-800-452-4800.

(11) Provide that no qualified long term care policy or certificate form shall be sold, transferred, or otherwise ceded to another issuer without first having obtained approval from the commissioner. This provision does not apply to:

(A) any reinsurance agreement or transaction in which the ceding issuer continues to remain directly liable for its insurance obligations or risks under the contracts of insurance subject to the reinsurance agreement; and

(B) the ceding issuer remains responsible for complying with all requirements of sections 37 *[section 37 of this rule was repealed filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001.]* through 42 of this rule.

(12) Except as provided in clause (A), an issuer shall continue to make available for purchase any qualified policy form or certificate form issued that has been approved by the commissioner. The following describe the process and result of discontinuing the availability of a qualified policy form or certificate form:

(A) An issuer may discontinue the availability of a qualified policy form or certificate form if the issuer provides the commissioner, in writing, its decision at least thirty (30) days prior to discontinuing the availability of the form of the qualified policy or certificate. The following shall be considered a discontinuance of the availability of a qualified policy form or certificate form:

(i) The sale or other transfer of a qualified policy form or certificate form to another issuer.

(ii) Failure to actively offer for sale a qualified policy form or certificate form in the previous twelve (12) months.

(iii) A change in the rating structure or methodology unless the issuer complies with the following requirements:

(AA) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(BB) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

(B) An issuer that discontinues the availability of a qualified policy form or certificate form under clause (A) shall not file for approval of a new long term care policy form or certificate form for a period of five (5) years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate. This clause does not apply if one (1) of the following are met:

(i) An issuer discontinues a qualified policy form or certificate form due to requirements from amendment to this article or IC 27-8-12.

(ii) All existing policyholders and certificateholders of a discontinued qualified policy form or certificate form who are not receiving benefits are notified by the issuer of the availability of the new benefits and provisions of the new qualified policy form by the time of their next renewal date and are offered the opportunity by the issuer to acquire the new benefits and/or provisions by either:

(AA) adding a qualified rider to the original qualified policy, in which case a separate premium, if any, will be calculated for the qualified rider based on the policyholder's original issue age; or

(BB) replacing the existing qualified policy with the new qualified policy form with the premium calculation for the new qualified policy based on the policyholder's original issue age.

This item does not prohibit an issuer for underwriting in accordance with the issuer's established underwriting standards, based on an application for the new qualified policy form or qualified rider.

(iii) The issuer pools the insureds of the existing qualified policy with the issuer's most current largest selling qualified policy for purposes of requesting future rate changes. In the event an issuer does not have another qualified policy in which to pool insureds of their existing qualified policy, the issuer shall pool insureds of the existing qualified policy with their most current largest selling nonqualified policy, or with another of their nonqualified policies as determined by the commissioner for purposes of requesting future rate changes.

(C) An issuer who discontinues selling qualified policies or any insurer who assumes a qualified policy from another insurer must continue to comply with the reporting requirements and maintaining auditing information requirements set forth in this article.

(13) Provide assurances to the department of insurance that in the event a change is made to a qualified policy or certificate that is eligible for favorable tax status that may affect its favorable tax status, the issuer shall disclose this fact to the policyholder or certificateholder prior to the change being made. And, at a minimum, the issuer shall advise the policyholder or certificateholder that they should consult a tax advisor.

(Department of Insurance; 760 IAC 2-20-34; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1149; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2646; errata filed Sep 28, 1994, 3:30 p.m.: 18 IR 268; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3370; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1990; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-35 Minimum benefit standards for qualifying policies, certificates, and riders

Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2

Sec. 35. No long term care insurance policy, certificate, or rider may be advertised, solicited, or issued for delivery in this state as a qualified long term care insurance policy, certificate, or rider which does not meet the minimum benefit standards in this section, and which has not been approved by the commissioner of the department of insurance as a qualified long term care insurance policy, certificate, or rider. These minimum standards do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. These standards are in addition to all other requirements of this article. In order to qualify for participation in the Indiana long term care program, a long term care insurance policy, certificate, or rider shall meet the following:

(1) Provide that maximum benefits be available in dollars and not in days of care.

(2) Include a provision of inflation protection which satisfies at least one (1) of the following criteria:

(A) The policy or certificate covers at least seventy-five percent (75%) of the average daily private pay rate.

(B) The policy or certificate provides for automatic increases in the per diem dollar level in accordance with either the Consumer Price Index or at five percent (5%) each year over the previous year for each year that the contract is in force.

(3) Provide that the unused maximum benefit amount of the policy, certificate, or rider increase proportionately with the inflation protection requirements of subdivision (2).

(Department of Insurance; 760 IAC 2-20-35; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1151; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2649; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-36 Required policy, certificate, and rider provisions

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 36. All qualified policies, certificates, and riders shall meet the following requirements:

(1) Have premiums:

(A) based on the issue age of the applicant; or

(B) level for the life of the policy or certificate.

Nothing in this subdivision shall preclude an issuer from reducing premiums of a policy or certificate or using a policy form or certificate form in which the premiums are no longer required to be paid after a specified period of time.

(2) Include a provision that the policy, certificate, or rider will utilize the insured event criteria, defined in section 21 of this rule, for determining eligibility for benefits and for determining the amount of asset disregard.

(3) Include a provision which, in the event the qualified policy or certificate is about to lapse, offers the policyholder or certificateholder the option to reduce his or her coverage to a lower benefit amount. However, this benefit amount offer, plus the amount of benefits used to date, cannot be less than the minimum benefit amount requirement specified in section 36.1(l) or 36.2(l) of this rule. The issuer need only allow this offer to be exercised one (1) time. Premiums shall be based on the age of the policyholder or certificateholder at the time of the issuance of the original qualified policy or certificate.

(4) Include a provision that, upon sale of a qualified long term care insurance policy or certificate, the issuer shall do the following:

(A) Offer to collect and store the name and address of an individual designated as an authorized designee by the purchaser to be notified when a policy or certificate lapse is imminent. The issuer must obtain a signed statement from purchasers who do not choose to designate an authorized designee that they have been offered this opportunity and declined. It shall be the issuer's responsibility to notify such designee prior to canceling a policy or certificate due to lack of premium payment. The designee notification shall occur no later than fifteen (15) days after the beginning of the thirty (30) day grace period for premium payments. The issuer shall permit the policyholder or certificateholder to periodically update the authorized designee.

(B) Provide at least a ninety (90) day guaranteed reinstatement period for a policyholder or certificateholder whose policy or certificate has lapsed due to nonpayment of premium, who meets the insured event criteria, and who has paid all due and unpaid premiums. The reinstated policy or certificate shall have the same benefits, terms, and premiums as the policy or certificate which lapsed.

(5) Include a provision that benefits shall only be paid after the payment of all other benefits to which the policyholder or certificateholder is otherwise entitled, excluding Medicaid. The issuer shall make reasonable efforts to determine whether benefits are available from other policies or certificates or from Medicare.

(6) Include a provision that the policy form shall not be changed or otherwise modified without the signed acceptance of the policyholder, or include a provision that the certificate form issued under a group long term care policy shall not be changed or otherwise modified without the signed acceptance of the certificateholder.

(7) For purposes of approving any future premium adjustments, all individual qualified policies issued by the same issuer shall be considered a single risk pool and all group qualified policies issued by the same issuer shall be considered a single risk pool, except a group issuer may form a separate risk pool whenever at least two thousand (2,000) certificates are in force for:

(A) a single employer, labor organization, or trust established by a single employer or labor organization;

(B) a single nonprofit association composed of individuals who are or were actively engaged in the same profession, trade, or occupation and organized in good faith for purposes other than obtaining insurance; and

(C) a single nonprofit association created and maintained in good faith for the benefit of its members and not for the purposes of obtaining insurance, in active existence for at least five (5) years, and with a constitution and bylaws and a board with member representation.

Nothing in this subdivision shall preclude an issuer from pooling their qualified and nonqualified policies, certificates, and riders to avoid or reduce the amount of any future premium increase that otherwise might have occurred to the risk pool of qualified policies, certificates, and riders.

(Department of Insurance; 760 IAC 2-20-36; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1152; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2650; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1993; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-36.1 Minimum benefit standards and required policy and certificate provisions for integrated policies

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 36.1. No long term care insurance policy or certificate may be advertised, solicited, or issued for delivery in this state as a qualified integrated policy or certificate which does not meet the minimum benefit standards and required policy and certificate provisions in this section, and which has not been approved by the commissioner of the department of insurance as a qualified long term care insurance policy or certificate. These minimum standards do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. These standards are in addition to all other requirements of this article. In order to

qualify for participation in the Indiana long term care program, an integrated policy or certificate must meet the following:

(1) Contain a maximum benefit amount equivalent to at least three hundred sixty-five (365) times the minimum daily nursing facility benefit defined in subdivision (3)(A).

(2) Offer a maximum benefit amount option equivalent to three hundred sixty-five (365) times the minimum daily nursing facility benefit defined in subdivision (3)(A). Issuers may offer other benefit amount options in addition to this minimum benefit amount option.

(3) At a minimum, upon the initial effective date, provide the following:

(A) A daily nursing facility benefit of at least seventy-five percent (75%) of the average daily private pay rate in nursing facilities rounded to the next highest five dollar ($5) or ten dollar ($10) increment. No policy or certificate shall pay benefits in excess of the actual charges.

(B) A daily home and community based benefit of at least fifty percent (50%) of the daily nursing facility benefit contained in the policy or certificate. No policy or certificate shall pay benefits in excess of the actual charges.

(C) The daily home and community based benefit shall not exceed the daily nursing facility benefit.

(4) If issued on an expense incurred basis, provide benefits which are equal to at least seventy-five percent (75%) of the per diem cost incurred by the insured.

(5) Include a provision that policy or certificate benefits can be used to purchase nursing facility care or home and community based care. Home and community based care shall include, at a minimum, but not be limited to, the following:

(A) Home health nursing.

(B) Home health aide services.

(C) Attendant care.

(D) Respite care.

(E) Adult day care services.

(6) All home and community based services shall include case management services delivered by a case management agency. The issuer may establish a limit on case management benefits. This limit shall not be less than thirteen (13) times the daily nursing home benefit per year. Case management benefits shall not count toward the policy's or certificate's maximum benefit.

(7) Issuers may include benefits for residential care facilities, as defined in section 31.1 of this rule, in an integrated policy or certificate. These policies must:

(A) provide a daily residential care facility benefit of at least fifty percent (50%) and no more than the daily nursing facility benefit contained in the policy or certificate;

(B) if issued on an expense incurred basis, provide a daily residential care facility benefit which does not exceed fifty percent (50%) of the per diem cost incurred by the insured; and

(C) include a provision that policy or certificate benefits can be used to purchase care in a nursing facility or residential care facility.

(Department of Insurance; 760 IAC 2-20-36.1; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2651; errata filed Sep 28, 1994, 3:30 p.m.: 18 IR 268; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1994; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-36.2 Minimum benefit standards and required policy and certificate provisions for long term care facility policies

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 36.2. No long term care insurance policy or certificate may be advertised, solicited, or issued for delivery in this state as a qualified long term care facility policy or certificate which does not meet the minimum benefit standards and required policy and certificate provisions in this section, and which has not been approved by the commissioner of the department of insurance as a qualified long term care insurance policy or certificate. These minimum standards do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. These standards are in addition to all other requirements of this article. In order to qualify for participation in the Indiana long term care program, a long term care facility policy or certificate must meet the following:

(1) Contain a maximum benefit amount equivalent to at least three hundred sixty-five (365) times the minimum daily nursing facility benefit defined in subdivision (3).

(2) Offer a maximum benefit amount option equivalent to three hundred sixty-five (365) times the minimum daily nursing facility benefit defined in subdivision (3). Issuers may offer other benefit amount options in addition to this minimum benefit amount option.

(3) At a minimum, upon the initial effective date, provide a daily nursing facility benefit of at least seventy-five percent (75%) of the average daily private pay rate in nursing facilities rounded to the next highest five dollar ($5) or ten dollar ($10) increment. No policy or certificate shall pay benefits in excess of the actual charges.

(4) If issued on an expense incurred basis, provide daily nursing facility benefits which are equal to at least seventy-five percent (75%) of the per diem cost incurred by the insured.

(5) Issuers may include benefits for residential care facilities, as defined in section 31.1 of this rule, in a long term care facility policy or certificate. Policies and certificates which include residential care facility benefits must:

(A) provide a daily residential care facility benefit of at least fifty percent (50%) and no more than the daily nursing facility benefit contained in the policy or certificate;

(B) if issued on an expense incurred basis, provide a daily residential care facility benefit which does not exceed fifty percent (50%) of the per diem cost incurred by the insured; and

(C) include a provision that policy or certificate benefits can be used to purchase care in a nursing facility or a residential care facility.

(Department of Insurance; 760 IAC 2-20-36.2; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2652; errata filed Sep 28, 1994, 3:30 p.m.: 18 IR 268; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1995; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-36.3 Minimum benefit standards and required policy and certificate provisions for qualified riders

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 36.3. (a) No long term care insurance rider may be advertised, solicited, or issued for delivery in this state as a qualified rider which does not meet the minimum benefit standards and required provisions in this section, and which has not been approved by the commissioner of the department of insurance as a qualified rider.

(b) An issuer may only attach a qualified rider to a qualified long term care policy sold by the same issuer.

(c) A qualified rider, which provides home and community based services, must provide benefits, at a minimum, but not be limited to, the following:

(1) Home health nursing.

(2) Home health aide services.

(3) Attendant care.

(4) Respite care.

(5) Adult day care services.

(d) All home and community based services covered through the qualified rider shall include case management services delivered by a case management agency. The issuer may establish a limit on case management benefits. This limit shall not be less than thirteen (13) times the daily nursing home benefit per year. Case management benefits shall not count toward the policy or certificate's maximum benefit.

(e) At a minimum, upon the initial effective date of the qualified rider, which provides home and community based services, the qualified rider must provide the following:

(1) A daily home and community based benefit of at least fifty percent (50%) of the then current daily nursing facility benefit of the long term care facility policy or certificate. No policy or certificate shall pay benefits in excess of the actual charges.

(2) The daily home and community based benefit shall not exceed the then current daily nursing facility benefit of the long term care facility policy or certificate.

(3) If issued on an expense incurred basis, provide benefits which are equal to at least seventy-five percent (75%) of the per diem cost incurred by the insured.

(f) At a minimum, upon the initial effective date of the qualified rider, which provides home and community based services, the qualified rider must provide a maximum benefit amount for the home and community care that:

(1) is at least fifty percent (50%) of the then current maximum total benefit amount of the long term care facility policy or certificate; and

(2) does not exceed the then current maximum benefit amount of the long term care facility policy or certificate.

(Department of Insurance; 760 IAC 2-20-36.3; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2652; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3373; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1996; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-37 Reporting requirements (Repealed)

Sec. 37. *(Repealed by Department of Insurance; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001)*

760 IAC 2-20-37.1 Reporting requirements

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 37.1. Unless otherwise noted, the following requirements refer to issuer documentation and reporting requirements for qualified policies and certificates:

(1) The reporting requirements shall adhere to the specifications put forth in the Partnership for Long Term Care Insurance Uniform Data Set (UDS) Manual. A printed copy of the Indiana Long Term Care Program reporting requirements and documentation shall be provided, upon request, by OMPP. Reports shall adhere to the most recent UDS specifications, including, but not limited to:

(A) reporting frequencies;
(B) file structures;
(C) file triggers and formats;
(D) field definitions; and
(E) state specific requirements as noted in the Indiana Long Term Care Program section of the state specific appendices of the UDS manual.

(2) All reports are due to OMPP no later than thirty (30) days after the close of the reporting periods specified for the respective reports.

(3) The reporting requirements may vary over time and will adhere to the most current requirements as specified in the UDS Reporting Requirements and Documentation Manual.

(Department of Insurance; 760 IAC 2-20-37.1; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1996; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-37.2 Reporting of agent data

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 37.2. Issuers of qualified policies or certificates shall submit agent sales data to OMPP two (2) times per year for purposes of creating and maintaining a directory of agents for consumers. The format, time frame of reporting periods, and due date for data will be specified by OMPP. *(Department of Insurance; 760 IAC 2-20-37.2; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1997; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-38 Maintaining auditing information

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 38. (a) Each issuer shall maintain information as stipulated in subsection (f) on all policyholders or certificateholders who have ever received any benefit under the policy or certificate. Such information shall be updated at least quarterly. This requirement for updating shall not require the conduct of any assessment, reassessment, or other evaluation of the policyholder's or certificateholder's condition which is not otherwise required by federal or state statute or regulation.

(b) When a policyholder or certificateholder who has received any benefits dies or when a policyholder or certificateholder who has received any benefits lapses his or her policy or certificate for any reason, the issuer must retain the stipulated information

for a period of at least five (5) years after the time the policy or certificate ceases to be in force or after the documented death of the policyholder or certificateholder. Unless notified by the department of insurance to the contrary during this period, after the five (5) years, the service summary provided by the issuer will be deemed to comply with all asset protection reporting, record keeping, and auditing requirements of this rule. The issuer may use microfiche, microfilm, optical storage media, or any other cost effective method of record storage as alternatives to storage of paper copies of stipulated information.

(c) At the time the policy or certificate ceases to be in force, the issuer shall notify the policyholder or certificateholder of his or her right to request his or her service records as stipulated in subsection (f).

(d) The issuer shall also, upon request in writing, provide such policyholder or certificateholder or the policyholder's or certificateholder's authorized designee, if any, with a copy of the issuer's service records as required in subsection (f) which are necessary to establish the asset disregard. These records shall be provided to the policyholder or certificateholder or the policyholder's or certificateholder's authorized designee, if requested, within sixty (60) days of the request. The issuer may charge a reasonable fee to cover the costs of providing each set of requested service record copies.

(e) The issuer shall enclose with the records a statement advising the former policyholder or certificateholder that it is in his or her interest to retain the records if he or she may ever wish to establish eligibility for Medicaid.

(f) The information to be maintained includes the following:

(1) Evidence that the insured event has taken place. The occurrence of the insured event may be documented in any of the following ways:

(A) By case management agency staff, as part of the initial assessment of the client or as part of a subsequent reassessment.

(B) By an assessment conducted as part of the preadmission screening program of DDARS.

(C) By an assessment of a resident of a nursing facility as required by Section 1919(b)(3) of the Social Security Act.

(D) For persons for whom clauses (A) through (C) are not available or do not provide the required information, by an assessment, carried out by or under the supervision of a physician or a registered nurse, which is substantially comparable to any of the methods in clauses (A) through (C). These assessments must be based on direct observations and interviews in conjunction with a medical record review. The physician or registered nurse carrying out or supervising the assessment must sign and certify the completion of the assessment. Each individual who completes a portion of such assessment shall sign and certify as to the accuracy of that portion of the assessment.

(2) Description of services provided under the policy or certificate, including the following:

(A) Name, address, phone number, and license number, if applicable, of provider.

(B) Amount, date, and type of services provided, and whether the services qualify for asset protection.

(C) Dollar amounts paid by the issuer, whether on an indemnity, expense incurred, or other basis.

(D) The charges of the service providers, including copies of invoices for all services counting towards asset protection.

(E) Identification of the case management agency, if applicable, and copies of all assessments and reassessments.

(3) In order for home and community based services to qualify for asset protection, these services must be in accord with a plan of care developed by a case management agency. If the policyholder or certificateholder has received any benefits delivered as part of a plan of care, the issuer must retain the following:

(A) A copy of the original plan of care.

(B) A copy of the plan of care required by DDARS.

(C) A copy of any changes made in the plan of care. The plan of care must document that the changes are required by changes in the client's medical situation, cognitive abilities, behavioral abilities, or the availability of social supports. Such services shall count towards asset protection after the case management agency adds the documented need for and description of the new services to the plan of care. In cases when the service must begin before the revisions to the plan of care are made, the new services will only count towards asset protection if the revisions to the plan of care are made within ten (10) business days of the commencement of the new services. Issuers must maintain initial assessments and subsequent reassessments as part of insured event documentation.

(Department of Insurance; 760 IAC 2-20-38; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1155; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2653; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1997; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-38.1 Determining asset protection

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 38.1. (a) Total asset protection for an individually owned qualified policy or certificate is earned when:

(1) the policy or certificate includes a maximum benefit equal to or greater than the state-set dollar amount in force on the original effective date of the policy or certificate;

(2) the maximum benefit was not reduced by the request of the policyholder or certificateholder during the term of the policy or certificate; and

(3) all of the qualified policy or certificate benefits have been exhausted.

(b) Total asset protection for a qualified policy or certificate that has had a reduction of coverage during the term of the policy or certificate is earned when:

(1) the policy or certificate includes a maximum benefit equal to or greater than the state-set dollar amount in force on the original effective date of the policy or certificate;

(2) the maximum benefit was reduced at the request of the policyholder or certificateholder during the term of the policy or certificate, and, at the time of the reduction, the new maximum benefit was equal to or greater than the state-set dollar amount in force during the calendar year in which the reduction took place disregarding any qualifying insurance benefits the policyholder or certificateholder may have already received from the policy or certificate being reduced; and

(3) all of the qualified policy or certificate benefits have been exhausted.

(c) Total asset protection for a qualified policy, certificate, or rider that allows spouses to share the benefits is earned when the policy or certificate includes a maximum benefit equal to or greater than the state-set dollar amount in force on the original effective date of the policy or certificate, and either:

(1) only one (1) spouse uses the policy or certificate benefits and exhausts all of the qualifying insurance benefits; or

(2) both spouses use the policy or certificate benefits and the remaining maximum benefit at the time the first spouse has permanently stopped using benefits is equal to or greater than the state-set dollar amount in force during that calendar year disregarding any qualifying insurance benefits the second spouse may have already received, and the second spouse exhausts the remaining qualifying insurance benefits.

(d) Dollar-for-dollar asset protection is earned for all other situations, which differ from (a), (b), and (c) *[subsections (a) through (c)]*.

(e) A qualified long term care insurance policy or certificate owned by an Indiana resident which was purchased as part of another state's Partnership for Long Term Care Program will earn dollar-for-dollar asset protection for the qualified insured if the other state's program is similar to the Indiana Long Term Care Program and OMPP has a reciprocity agreement with the other state's Medicaid program.

(f) Benefits paid in excess of the actual charges do not earn asset protection.

(g) Benefits paid that are not based upon the insured event criteria do not earn asset protection.

(h) Home and community care benefits paid without case management do not earn asset protection. *(Department of Insurance; 760 IAC 2-20-38.1; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1998; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-39 Reporting on asset protection

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 39. (a) Each issuer shall send an asset protection report at least quarterly, with a copy sent to OMPP, to each policyholder or certificateholder who has received any benefits since the last asset protection report sent to the policyholder or certificateholder. Each asset protection report shall include the following information and shall appear in a format prescribed by OMPP:

(1) The amount of asset protection for which the policyholder or certificateholder had qualified prior to the quarter covered by the report.

(2) The total benefits paid by the issuer for services rendered during the quarter.

(3) A statement of the amount of benefits paid by the issuer for services rendered during the quarter which qualify for asset protection.

(4) A summary total of the amount paid to date under the policy or certificate that qualifies for asset protection.

(b) Asset protection reports shall be subject to audit by OMPP serving as representative of the commissioner of the department of insurance under the same requirements as specified in section 41(2) of this rule which covers the records in section 38 of this rule. *(Department of Insurance; 760 IAC 2-20-39; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1156; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1998; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-40 Preparing a service summary

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 40. (a) Each issuer shall prepare a service summary at the client's request specifically for the policyholder or certificateholder applying for Medicaid. The issuer shall also prepare a service summary when the policyholder or certificateholder has exhausted his or her benefits under the policy or certificate or when the policy or certificate ceases to be in force for a reason other than the death of the policyholder or certificateholder, whichever occurs first. The issuer shall send the service summary to the policyholder or certificateholder, with a copy sent to OMPP, within thirty (30) days of the date of final payment of qualifying insurance benefits by the issuer.

(b) The service summary shall include the following and shall appear in a format prescribed by OMPP:

(1) The specific qualified policy or certificate.

(2) The total benefits paid for services rendered to date.

(3) The amount qualifying for asset protection.

This service summary is separate and in addition to the information requirement described in section 38 of this rule. *(Department of Insurance; 760 IAC 2-20-40; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1156; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1999; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-41 Plan of action

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 41. (a) Each issuer shall, prior to qualification by the department of insurance, submit to OMPP a plan for complying with the information maintenance and documentation requirements set forth in sections 37.1 and 38 of this rule. No policy or certificate shall be qualified until OMPP has approved the issuer's documentation plan for the policy or certificate. The documentation plan will include the following:

(1) The location where records will be kept. Records required for purposes of the Indiana long term care program must be available at no more than three (3) locations, each of which shall be easily accessible to OMPP serving as representative of the department of insurance.

(2) The issuer shall agree to give OMPP access to all information described in section 38 of this rule on an aggregate basis for all policyholders or certificateholders and on an individual basis for all policyholders or certificateholders who have ever received any benefits. Access to information on persons who have not applied for Medicaid is required in order to determine if an issuer's system for documenting asset protection is functioning correctly. The OMPP shall have the final decision concerning the frequency of access to the data and the size of samples for auditing or other purposes.

(3) The name, job title, address, and telephone number of the person primarily responsible for the maintenance of the information required and for acting as liaison with OMPP and the department of insurance concerning the information.

(4) Methods for determining when insurance benefits or prepaid benefits qualify for asset protection, including the following:

(A) Documentation of the insured event.

(B) Description of services.

(C) Documentation of charges and benefits paid.

(D) Documentation of plans of care, when required.

(5) Description of electronic and manual systems which will be used in maintaining the required information.

(6) Information that will be retained which is needed to comply with this rule.

(7) Copies of forms and descriptions of standard procedures for maintaining and reporting the information required, including

the specific electronic medium that will be used to report required information and a description of the relevant files.

(b) After OMPP reviews a plan of action, OMPP shall advise the department of insurance and the issuer in writing whether OMPP approves the plan of action. If OMPP disapproves a plan of action, OMPP shall advise the department of insurance and the issuer of the shortcomings in the plan of action and shall instruct the issuer of the methods necessary to resolve them. *(Department of Insurance; 760 IAC 2-20-41; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1156; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1999; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-42 Auditing and correcting deficiencies in issuer record keeping

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 42. (a) Within one (1) year of the first date that any policyholder or certificateholder of a particular issuer's policy or certificate has met the criteria for the insured event, and as often as the commissioner or OMPP deems necessary thereafter, OMPP as representative of the commissioner shall conduct a systems audit of that company's records. The issuer shall be responsible for advising OMPP and the department of insurance when this one (1) year period has begun. OMPP shall promptly inform each issuer of inaccuracies and other potential problems discovered in its systems audits, and shall instruct the issuer of the methods necessary to correct any problems in the issuer's methods of operation. It is the responsibility of the issuer to make any necessary corrections.

(b) OMPP shall periodically reconcile a sample of individual applications to Medicaid of persons who have submitted documentation for qualification for asset protection with the reports submitted by issuers. OMPP shall have the final decision concerning sample sizes and other auditing methods. OMPP shall promptly advise issuers of any problems discovered and shall instruct the issuer of the methods necessary to correct any problems in the issuer's method of operation. OMPP shall also notify the issuer of any obligations described in this subsection to hold clients harmless.

(c) The assistant secretary of OMPP or other authorized individual may enter into voluntary arrangements with issuers of qualified long term care insurance policies and certificates under which the assistant secretary would issue binding determinations as to whether or not services qualify for asset protection. Policyholders or certificateholders may submit requests for information and advice through their issuer or case management agency. When the following procedures are followed in all material respects, the written determinations of the assistant secretary of OMPP or other authorized individual concerning whether services qualify for asset protection shall be binding upon OMPP in all subsequent actions, and OMPP shall not make any assertion contradicting these determinations in any action arising in this subsection:

(1) All requests for determinations as to whether or not services qualify for asset protection shall be submitted to the assistant secretary of OMPP or other authorized individual in writing. These requests may include, but are not limited to, requests for determinations in the following areas:

(A) Whether the insured event has occurred and has been adequately documented.
(B) Whether a care plan is required.
(C) Whether a revision of a care plan is required.
(D) Whether a service or services are in accord with the care plan.
(E) Whether a service is of such a nature as to qualify for asset protection.
(F) Whether the applicable amount is the amount paid by the issuer or the amount charged for the service.

(2) The assistant secretary of OMPP or other authorized individual may require issuers and case management agencies submitting requests for determination to provide all records and other information necessary for making a determination. The records and other information may include, but are not limited to, the following:

(A) Assessments.
(B) Care plans.
(C) Invoices for services rendered.

The party providing the records and other information shall be responsible for their accuracy. If any records or other information are *[sic., is]* later determined to be materially inaccurate, the determination based on the inaccurate information shall be void and not be binding on OMPP or any other person or entity in subsequent actions. In the case of a policyholder or certificateholder for whom a determination has been invalidated because information provided was determined to be inaccurate, the provisions of subsections (f) and (g) will apply in the same manner as for any other policyholder or certificateholder.

(3) The assistant secretary of OMPP or other authorized individual shall render his or her determination on each request in writing. Each determination of the assistant secretary of OMPP or other authorized individual shall state the reason for his or her determination, including the following:

(A) Relevant facts.

(B) Documentation of facts.

(C) Statutes.

(D) Regulations.

(E) Policies.

(4) A copy of all determinations of the assistant secretary of OMPP or other authorized individual shall be kept on file at OMPP, together with the related records and information. The original of the determination shall be sent to the issuer or the case management agency that originally requested it. The recipient of the original determination shall be responsible for notifying the policyholder or certificateholder or the policyholder's or certificateholder's authorized agent.

(d) When an audit or other review by OMPP reveals deficiencies in the record keeping procedures of an issuer, OMPP will notify the issuer of the deficiencies and establish a reasonable deadline for correction. If an issuer fails to correct deficiencies discovered by OMPP within a reasonable period of time, OMPP will notify the department of insurance of the deficiencies.

(e) The commissioner of the department of insurance, upon consultation with OMPP, shall reserve the right to remove qualification status of long term care insurance policies and certificates when deemed necessary. Failure to comply with any of the provisions of this article can be grounds for the removal of qualification status. If the department of insurance removes qualification status from a long term care insurance policy or certificate, a policyholder or certificateholder who purchased his or her policy or certificate while the policy or certificate was qualified will retain his or her right to asset protection. A policyholder or certificateholder who purchases his or her policy or certificate after the removal of qualification status will have no right to asset protection. Any issuer who has their qualification status removed must continue to comply with the reporting requirements and maintaining auditing information requirements set forth in this article.

(f) If an issuer prepares a service summary which is used in a Medicaid application for a policyholder or certificateholder and the client is found eligible for Medicaid, and the policyholder or certificateholder after receiving Medicaid services is found to be ineligible for Medicaid solely by reason of errors in the issuer's service summary or documentation of services, OMPP may require the issuer to pay for services counting towards asset protection required by the policyholder or certificateholder until the issuer has paid an amount equal to the amount of the issuer's errors; after which the policyholder or certificateholder, if otherwise eligible, could qualify for Medicaid coverage.

(g) If OMPP determines that an issuer's records pertaining to a policyholder or certificateholder who has received Medicaid benefits are in such condition that OMPP cannot determine whether the policyholder or certificateholder qualifies for asset protection, OMPP may require the issuer to pay for services counting towards asset protection required by the policyholder or certificateholder until the issuer has paid an amount equal to the amount of the issuer's error; after which the policyholder or certificateholder, if otherwise eligible, could qualify for Medicaid coverage.

(h) OMPP shall serve as the representative of the commissioner for all audits and examinations that may be required to determine compliance with this article.

(i) Compliance with subsections (f) and (g) is a requirement for a policy or certificate to retain qualification. *(Department of Insurance; 760 IAC 2-20-42; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1157; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2000; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-43 Separability

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 43. If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid or unenforceable, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby. *(Department of Insurance; 760 IAC 2-20-43; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1159; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

ARTICLE 3. MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

Rule 1. General Provisions

760 IAC 3-1-1 Applicability and scope

Authority: IC 27-8-13-10
Affected: IC 27-8-13-1

Sec. 1. (a) Except as otherwise specifically provided in 760 IAC 3-5, 760 IAC 3-11, 760 IAC 3-14, and 760 IAC 3-19, this article shall apply to the following:

(1) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation.

(2) All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

(b) This article shall not apply to a policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations. *(Department of Insurance; 760 IAC 3-1-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2563; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3412; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 2. Definitions

760 IAC 3-2-1 Applicability

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 1. The definitions in this rule apply throughout this article. *(Department of Insurance; 760 IAC 3-2-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2563; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-2 "Applicant" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 2. "Applicant" means:

(1) in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; or

(2) in the case of a group Medicare supplement policy, the proposed certificate holder.

(Department of Insurance; 760 IAC 3-2-2; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2563; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 3-2-2.5 "Bankruptcy" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 2.5. As used in this rule, "bankruptcy" means when a Medicare+Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in Indiana. *(Department of Insurance; 760 IAC 3-2-2.5; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1972; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-3 "Certificate" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 3. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement

policy. *(Department of Insurance; 760 IAC 3-2-3; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-4 "Certificate form" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 4. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer. *(Department of Insurance; 760 IAC 3-2-4; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-4.5 "Continuous period of creditable coverage" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 4.5. As used in this rule, "continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days. *(Department of Insurance; 760 IAC 3-2-4.5; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1972; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-4.6 "Creditable coverage" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 4.6. (a) As used in this rule, "creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(1) A group health plan.
(2) Health insurance coverage.
(3) Part A or Part B of Title XVIII of the Social Security Act (Medicare).
(4) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928.
(5) Chapter 55 of Title 10, United States Code (CHAMPUS).
(6) A medical care program of the Indian Health Service or of a tribal organization.
(7) A state health benefits risk pool.
(8) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program).
(9) A public health plan as defined in federal regulation.
(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

(b) The term shall not include one (1) or more, or any combination of, the following:

(1) Coverage only for accident or disability income insurance, or any combination thereof.
(2) Coverage issued as a supplement to liability insurance.
(3) Liability insurance, including general liability insurance and automobile liability insurance.
(4) Workers' compensation or similar insurance.
(5) Automobile medical payment insurance.
(6) Credit-only insurance.
(7) Coverage for on-site medical clinics.
(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(c) The term shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits.
(2) Benefits for long term care, nursing home care, home health care, community-based care, or any combination thereof.

(3) Such other similar, limited benefits as are specified in federal regulations.
(d) The term shall not include the following benefits if offered as independent, noncoordinated benefits:
(1) Coverage only for a specified disease or illness.
(2) Hospital indemnity or other fixed indemnity insurance.
(e) The term shall not include the following if it is offered as a separate policy, certificate, or contract of insurance:
(1) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act.
(2) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code.
(3) Similar supplemental coverage provided to coverage under a group health plan.
(Department of Insurance; 760 IAC 3-2-4.6; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1972; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 3-2-4.7 "Employee welfare benefit plan" defined
Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 4.7. As used in this rule, "employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in 29 U.S.C. 1002 (Employee Retirement Income Security Act). *(Department of Insurance; 760 IAC 3-2-4.7; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1973; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-4.8 "Insolvency" defined
Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 4.8. As used in this rule, "insolvency" means when an issuer, licensed to transact the business of insurance in Indiana, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile. *(Department of Insurance; 760 IAC 3-2-4.8; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1973; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-5 "Issuer" defined
Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 5. "Issuer" means insurance companies, fraternal benefit societies, prepaid health care delivery plans, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates. *(Department of Insurance; 760 IAC 3-2-5; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-6 "Medicare" or "Medicare program" defined
Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 6. "Medicare" or "Medicare program" means the "Health Insurance for the Aged Act", Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended. *(Department of Insurance; 760 IAC 3-2-6; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-6.1 "Medicare+Choice organization" defined
Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 6.1. As used in this rule, "Medicare+Choice organization" has the meaning as set forth in 42 U.S.C. 1395w-28.

(Department of Insurance; 760 IAC 3-2-6.1; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1973; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 3-2-6.2 "Medicare+Choice plan" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 6.2. As used in this rule, "Medicare+Choice plan" has the meaning as set forth in 42 U.S.C. 1395w-28. *(Department of Insurance; 760 IAC 3-2-6.2; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1973; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-7 "Medicare supplement policy" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 7. "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the Social Security Act (42 U.S.C. §1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. 1395ss(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. *(Department of Insurance; 760 IAC 3-2-7; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3413; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-8 "Policy form" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 8. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer. *(Department of Insurance; 760 IAC 3-2-8; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-2-9 "Secretary" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 9. As used in this rule, "Secretary" means the Secretary of the United States Department of Health and Human Services. *(Department of Insurance; 760 IAC 3-2-9; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1974; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 3. Policy Definitions and Terms

760 IAC 3-3-1 Policy definitions and terms

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 1. (a) No policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this article.

(b) "Accident", "accidental injury", or "accidental means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization and as follows:

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person, which is the direct result of an accident, independent of disease or

bodily infirmity or any other cause, and occurs while insurance coverage is in force.".

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(c) "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

(d) "Convalescent nursing home", "extended care facility", or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

(e) "Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. Such expenses shall not include the following:

(1) Home office and overhead costs.

(2) Advertising costs.

(3) Commissions and other acquisition costs.

(4) Taxes.

(5) Capital costs.

(6) Administrative costs.

(7) Claims processing costs.

(f) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

(g) "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import.

(h) "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

(i) "Physician" shall not be defined more restrictively than as defined by Medicare.

(j) "Sickness" shall not be defined to be more restrictive than the following:

(1) "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.".

(2) The definition in subdivision (1) may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

(Department of Insurance; 760 IAC 3-3-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; errata filed Sep 20, 1993, 5:00 p.m.: 17 IR 200; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 4. Policy Provisions

760 IAC 3-4-1 Policy provisions

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 1. (a) Except for permitted preexisting condition clauses as described in 760 IAC 3-5-1(b)(1) and 760 IAC 3-6-1(b), no policy or certificate shall be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(b) No Medicare supplement policy or certificate may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(c) No Medicare supplement policy or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare. *(Department of Insurance; 760 IAC 3-4-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2565; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 5. Minimum Benefit Standards

760 IAC 3-5-1 Minimum benefit standards for policies or certificates issued for delivery prior to January 1, 1992

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 1. (a) No policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy or certificate prior to January 1, 1992, unless it meets or exceeds the minimum standards in this section. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(b) The following standards apply to Medicare supplement policies and certificates issued prior to January 1, 1992, and are in addition to all other requirements of this article:

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) A "noncancellable", "guaranteed renewable", or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

(A) provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(B) be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(5) Except as authorized by the commissioner of the department of insurance in this state, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(6) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subdivision (8), the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

(A) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy.

(B) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in 760 IAC 3-6-1(c).

(7) If membership in a group is terminated, the issuer shall:

(A) offer the certificate holder such conversion opportunities as are described in subdivision (6); or

(B) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(8) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(9) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

(c) Minimum benefit standards are as follows:

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period.

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount.

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days.

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days.

(5) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B.

(6) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible (one hundred dollars ($100)).

(d) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount. *(Department of Insurance; 760 IAC 3-5-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2565; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3413; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 6. Benefit Standards

760 IAC 3-6-1 Benefit standards for policies or certificates issued or delivered on or after December 31, 1991

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 1. (a) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with benefit standards in this section.

(b) The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this article:

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable and shall meet the following requirements:

(A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under clause (E), the issuer shall offer certificate holders an individual Medicare supplement policy which at the option of the certificate holder:

(i) provides for continuation of the benefits contained in the group policy; or

(ii) provides for such benefits as otherwise meets the requirements of this subsection.

(D) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(i) offer the certificate holder the conversion opportunity described in clause (C); or

(ii) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group

policy.

(E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

(7) Each Medicare supplement policy shall do the following:

(A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.

(B) If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificate holder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(C) Reinstitution of such coverages:

(i) shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(iii) shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(c) Every issuer shall make available a policy or certificate including only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu thereof. The standards for basic core benefits common to all benefit plans are as follows:

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period.

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the diagnostic related group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(d) The additional benefits shall be included in Medicare supplement benefit Plans B through J only as provided by 760 IAC 3-7. The standards for additional benefits are as follows:

(1) Medicare Part A deductible, coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled nursing facility care, coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B deductible, coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
(4) Eighty percent (80%) of the Medicare Part B excess charges, coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law and the Medicare approved Part B charge.
(5) One hundred percent (100%) of the Medicare Part B excess charges, coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law and the Medicare approved Part B charge.
(6) Basic outpatient prescription drug benefit, coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare.
(7) Extended outpatient prescription drug benefit, coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare.
(8) Medically necessary emergency care in a foreign country, coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.
(9) Preventive medical care benefit, coverage for the following preventive health services:

(A) An annual clinical preventive medical history and physical examination that may include tests and services from clause (B) and patient education to address preventive health care measures.

(B) Any one (1) or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(i) Fecal occult blood test and/or digital rectal examination.

(ii) Mammogram.

(iii) Dipstick urinalysis for hematuria, bacteriuria, and proteinuria.

(iv) Pure tone (air only) hearing screening test, administered or ordered by a physician.

(v) Serum cholesterol screening (every five (5) years).

(vi) Thyroid function test.

(vii) Diabetes screening.

(C) Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster (every ten (10) years).

(D) Any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.
(10) At-home recovery benefit, coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery, including the following requirements:

(A) For purposes of this subdivision, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would

qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four (24) hour period of services provided by a care provider is one (1) visit.

(B) Coverage requirements and limitations are as follows:

(i) At-home recovery services provided must be primarily services which assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to the following:

(AA) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

(BB) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit.

(CC) One thousand six hundred dollars ($1,600) per calendar year.

(DD) Seven (7) visits in any one (1) week.

(EE) Care furnished on a visiting basis in the insured's home.

(FF) Services provided by a care provider as defined in clause (A)(ii).

(GG) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(HH) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(iv) Coverage is excluded for the following:

(AA) Home care visits paid for by Medicare or other government programs.

(BB) Care provided by family members, unpaid volunteers, or providers who are not care providers.

(11) An issuer may, with the prior approval of the commissioner of the department of insurance, offer a policy or certificate with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

(Department of Insurance; 760 IAC 3-6-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2566; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3414; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 7. Standard Medicare Supplement Benefit Plans

760 IAC 3-7-1 Standard Medicare supplement benefit plans

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 1. (a) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits as defined in 760 IAC 3-6-1(c).

(b) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in 760 IAC 3-6-1(d)(11) and 760 IAC 3-8.

(c) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit Plans A through J listed in this section and conform to the definitions in 760 IAC 3-2 and 760 IAC 3-3. Each benefit shall be structured in accordance with the format provided in 760 IAC 3-6-1(c) through 760 IAC 3-6-1(d) and list the benefits in the order shown in subsection (e). As used in this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(d) An issuer may use, in addition to the benefit plan designations required in subsection (c), other designations to the extent permitted by law.

(e) Makeup of benefit plans shall be as follows:
(1) Standardized Medicare supplement benefit Plan A shall be limited to the basic (core) benefits common to all benefit plans as defined in 760 IAC 3-6-1(c).
(2) Standardized Medicare supplement benefit Plan B shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus the Medicare Part A deductible as defined in 760 IAC 3-6-1(d)(1).
(3) Standardized Medicare supplement benefit Plan C shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:
(A) Medicare Part A deductible;
(B) skilled nursing facility care;
(C) Medicare Part B deductible; and
(D) medically necessary emergency care in a foreign country;
as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(3) and 760 IAC 3-6-1(d)(8), respectively.
(4) Standardized Medicare supplement benefit Plan D shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:
(A) Medicare Part A deductible;
(B) skilled nursing facility care;
(C) medically necessary emergency care in a foreign country; and
(D) at-home recovery benefit;
as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(2), 760 IAC 3-6-1(d)(8), and 760 IAC 3-6-1(d)(10), respectively.
(5) Standardized Medicare supplement benefit Plan E shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:
(A) Medicare Part A deductible;
(B) skilled nursing facility care;
(C) medically necessary emergency care in a foreign country; and
(D) preventive medical care;
as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(2) and 760 IAC 3-6-1(d)(8) through 760 IAC 3-6-1(d)(9), respectively.
(6) Standardized Medicare supplement benefit Plan F shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:
(A) Medicare Part A deductible;
(B) skilled nursing facility care;
(C) Part B deductible;
(D) one hundred percent (100%) of the Medicare Part B excess charges; and
(E) medically necessary emergency care in a foreign country;
as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(3), 760 IAC 3-6-1(d)(5), and 760 IAC 3-6-1(d)(8), respectively.
(7) Standardized Medicare supplement benefit high deductible Plan F shall include one hundred percent (100%) of covered expenses following the payment of the annual high deductible Plan F deductible. The covered expenses include the core benefit as defined in 760 IAC 3-6-1(c), plus:
(A) Medicare Part A deductible;
(B) skilled nursing facility care;
(C) Medicare Part B deductible;
(D) one hundred percent (100%) of the Medicare Part B excess charges; and
(E) medically necessary emergency care in a foreign country;
as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(2) and 760 IAC 3-6-1(d)(8) through 760 IAC 3-6-1(d)(9), respectively. The annual high deductible Plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan F deductible shall be one thousand five hundred dollars ($1,500) for 1999 and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12) month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).
(8) Standardized Medicare supplement benefit Plan G shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:
(A) Medicare Part A deductible;
(B) skilled nursing facility care;
(C) eighty percent (80%) of the Medicare Part B excess charges;

(D) medically necessary emergency care in a foreign country; and
(E) at-home recovery benefit;

as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(2), 760 IAC 3-6-1(d)(4), 760 IAC 3-6-1(d)(8), and 760 IAC 3-6-1(d)(10), respectively.

(9) Standardized Medicare supplement benefit Plan H shall consist of only the core benefit as defined in 760 IAC 3-6-1(c), plus:

(A) Medicare Part A deductible;
(B) skilled nursing facility care;
(C) basic prescription drug benefit; and
(D) medically necessary emergency care in a foreign country;

as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(2), 760 IAC 3-6-1(d)(6), and 760 IAC 3-6-1(d)(8), respectively.

(10) Standardized Medicare supplement benefit Plan I shall consist of only the core benefit as defined in 760 IAC 3-6-1(c), plus:

(A) Medicare Part A deductible;
(B) skilled nursing facility care;
(C) one hundred percent (100%) of the Medicare Part B excess charges;
(D) basic prescription drug benefit;
(E) medically necessary emergency care in a foreign country; and
(F) at-home recovery benefit;

as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(2), 760 IAC 03-6-1(d)(5) *[sic., 760 IAC 3-6-1(d)(5)]* through 760 IAC 3-6-1(d)(6), 760 IAC 3-6-1(d)(8), and 760 IAC 3-6-1(d)(10), respectively.

(11) Standardized Medicare supplement benefit Plan J shall consist of only the core benefit as defined in 760 IAC 3-6-1(c), plus:

(A) Medicare Part A deductible;
(B) skilled nursing facility care;
(C) Medicare Part B deductible;
(D) one hundred percent (100%) of the Medicare Part B excess charges;
(E) extended prescription drug benefit;
(F) medically necessary emergency care in a foreign country;
(G) preventive medical care; and
(H) at-home recovery benefit;

as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(3), 760 IAC 3-6-1(d)(5), and 760 IAC 3-6-1(d)(7) through 760 IAC 3-6-1(d)(10), respectively.

(12) Standardized Medicare supplement benefit high deductible Plan J shall consist of one hundred percent (100%) of covered expenses following the payment of the annual high deductible Plan J deductible. The covered expenses include the core benefit as defined in 760 IAC 3-6-1(c), plus:

(A) Medicare Part A deductible;
(B) skilled nursing facility care;
(C) Medicare Part B deductible;
(D) one hundred percent (100%) of the Medicare Part B excess charges;
(E) extended outpatient prescription drug benefit;
(F) medically necessary emergency care in a foreign country;
(G) preventive medical care benefit; and
(H) at-home recovery benefit;

as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(3), 760 IAC 3-6-1(d)(5), and 760 IAC 3-6-1(d)(7) through 760 IAC 3-6-1(d)(10), respectively. The annual high deductible Plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan J policy and shall be in addition to any other specific benefit deductibles. The annual high deductible shall be one thousand five hundred dollars ($1,500) for 1999 and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12) month period ending with August of the preceding year, and rounded to

the nearest multiple of ten dollars ($10).

(Department of Insurance; 760 IAC 3-7-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2569; errata filed Sep 20, 1993, 5:00 p.m.: 17 IR 200; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1974; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 8. Medicare Select Policies and Certificates

760 IAC 3-8-1 Medicare select policies and certificates

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 1. (a) This section shall apply to Medicare select policies and certificates as defined in this section.

(b) No policy or certificate may be advertised as a Medicare select policy or certificate unless it meets the requirements of this section.

(c) The following definitions apply throughout this section:

(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare select issuer or its network providers.

(2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare select issuer or its network providers.

(3) "Medicare select issuer" means an issuer offering, or seeking to offer, a Medicare select policy or certificate.

(4) "Medicare select policy" or "Medicare select certificate" means, respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare select policy.

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the commissioner of the department of insurance within which an issuer is authorized to offer a Medicare select policy.

(d) The commissioner may authorize an issuer to offer a Medicare select policy or certificate, under this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the commissioner of the department of insurance finds that the issuer has satisfied all of the requirements of this article.

(e) A Medicare select issuer shall not issue a Medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner of the department of insurance.

(f) A Medicare select issuer shall file a proposed plan of operation with the commissioner of the department of insurance in a format prescribed by the commissioner of the department of insurance. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration of the following:

(A) Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(B) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) to deliver adequately all services that are subject to a restricted network provision; or

(ii) to make appropriate referrals.

(C) There are written agreements with network providers describing specific responsibilities.

(D) Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

(E) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare select policy or certificate. This clause

shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the quality assurance program, including the following:

(A) The formal organizational structure.

(B) The written criteria for selection, retention, and removal of network providers.

(C) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) A list and description, by specialty, of the network providers.

(6) Copies of the written information proposed to be used by the issuer to comply with subsection (k).

(7) Any other information requested by the commissioner of the department of insurance.

(g) A Medicare select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner of the department of insurance prior to implementing such changes. Such changes shall be considered approved by the commissioner of the department of insurance after thirty (30) days unless specifically disapproved.

(h) An updated list of network providers shall be filed with the commissioner of the department of insurance at least quarterly.

(i) A Medicare select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if:

(1) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition; and

(2) it is not reasonable to obtain such services through a network provider.

(j) A Medicare select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(k) A Medicare select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate with the following:

(A) Other Medicare supplement policies or certificates offered by the issuer.

(B) Other Medicare select policies or certificates.

(2) A description, including address, phone number, and hours of operation of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.

(4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

(7) A description of the Medicare select issuer's quality assurance program and grievance procedure.

(l) Prior to the sale of a Medicare select policy or certificate, a Medicare select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided under subsection (k) and that the applicant understands the restrictions of the Medicare select policy or certificate.

(m) A Medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures as follows:

(1) The grievance procedure shall be described in the policies and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31 to the commissioner of the department of insurance regarding its

grievance procedure. The report shall be in a format prescribed by the commissioner of the department of insurance and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.

(n) At the time of initial purchase, a Medicare select issuer shall make available to each applicant for a Medicare select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(o) At the request of an individual insured under a Medicare select policy or certificate, a Medicare select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer that:

(1) has comparable or lesser benefits; and

(2) does not contain a restricted network provision.

The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare select policy or certificate has been in force for six (6) months.

(p) For purposes of subsection (o), a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare select policy or certificate being replaced. As used in this subsection, "significant benefit" means coverage for:

(1) the Medicare Part A deductible;

(2) prescription drugs;

(3) at-home recovery services; or

(4) Part B excess charges.

(q) Medicare select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare select policies and certificates issued under this section should be discontinued due to either the failure of the Medicare select program to be reauthorized under law or its substantial amendment and as follows:

(1) Each Medicare select issuer shall make available to each individual insured under a Medicare select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

(2) For purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare select policy or certificate being replaced. As used in this subdivision, "significant benefit" means coverage for:

(A) the Medicare Part A deductible;

(B) prescription drugs;

(C) at-home recovery services; or

(D) Part B excess charges.

(r) A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare select program. *(Department of Insurance; 760 IAC 3-8-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2570; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3417; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 9. Open Enrollment

760 IAC 3-9-1 Open enrollment

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 1. (a) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

(b) If an applicant qualifies under subsection (a) and submits an application during the time period referenced in subsection (a) and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

(c) If an applicant qualifies under subsection (a) and submits an application during the time period referenced in subsection (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the sum of the period of creditable coverage applicable to the applicant as of the enrollment date.

(d) Except as provided in this section and 760 IAC 3-19-1, subsection (a) shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective. *(Department of Insurance; 760 IAC 3-9-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2573; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3419; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1975; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 3-9-2 Guaranteed issue for eligible persons

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 2. (a) As used in this section, "eligible person" means an individual described in any of the following:

(1) An individual enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and the plan terminates or the plan implements a material reduction of supplemental health benefits to the individual, or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates, or the plan ceases to provide health benefits to the individual because the individual leaves the plan.

(2) An individual enrolled with a Medicare+Choice organization under a Medicare+Choice plan and any of the following circumstances apply:

(A) The organization's or plan's certification has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(B) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area.

(C) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual. or

(D) The individual meets such other exceptional conditions as the Secretary may provide.

(3) An individual enrolled in one (1) of the following:

(A) an eligible organization under a contract under Section 1876 (Medicare risk or cost);

(B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(C) an organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or

(D) an organization under a Medicare Select policy;

and the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subsection (a)(2) of this section *[subdivision (2)]*.

(4) An individual enrolled under a Medicare supplement policy and the enrollment ceases due to one (1) of the following:

(A) Insolvency of the issuer, bankruptcy of the organization, or other involuntary termination of coverage or enrollment under the policy.

(B) The issuer of the policy substantially violated a material provision of the policy. or

(C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(5) An individual enrolled under a Medicare supplement policy who:

(A) terminates enrollment and subsequently enrolls with:

(i) any Medicare+Choice organization under Medicare+Choice plans;

(ii) any eligible organization under a contract under Section 1876 (Medicare risk or cost) or any similar organization operating under demonstration project authority;

(iii) an organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or

(iv) a Medicare Select policy; and

(B) during the first twelve (12) months after the initial termination of enrollment from the Medicare supplement policy under clause (A), the individual:

(i) terminates any subsequent enrollments in plans or organizations described in clause (A)(i), (A)(ii), (A)(iii), or (A)(iv); and

(ii) applies to enroll with a Medicare supplement policy.

(6) An individual who, upon first enrolling in Medicare Part B, enrolls in any Medicare+Choice plans and disenrolls from the plans not later than twelve (12) months after the effective date of the individual's first enrollment.

(b) With respect to eligible persons who apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection (a) and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy, an issuer shall not:

(1) deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (c) that is offered and is available for issuance to new enrollees by the issuer;

(2) discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; and

(3) impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(c) An eligible person as defined by subsection (a)(1), (a)(2), (a)(3), or (a)(4) is guaranteed issuance of a standardized Medicare supplement benefit Plan A, Plan B, Plan C, or Plan F offered by any issuer.

(d) An eligible person as defined by subsection (a)(5) is guaranteed issuance of the same standardized Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in subsection (c).

(e) An eligible person as defined by subsection (a)(6) is guaranteed issuance of any standardized Medicare supplement policy offered by any issuer.

(f) At the time of an event described in subsection (a), either the organization that terminates the contract or agreement, the employee welfare benefit plan, the issuer of the policy, or the administrator of the plan being terminated shall notify the individual of his or her rights under this section.

(g) At the time of an event described in subsection (a) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, either the organization that offers the contract or agreement, the issuer offering the policy, or the administrator of the plan shall notify the individual of his or her rights under this section. Such notice shall be communicated to the individual within ten (10) working days of the issuer receiving notification of disenrollment. *(Department of Insurance; 760 IAC 3-9-2; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1976; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 10. Standards for Claims Payment

760 IAC 3-10-1 Claims payment

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 1. (a) An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by doing the following:

(1) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis

of the information contained in that notice.

(2) Notifying the participating physician or supplier and the beneficiary of the payment determination.

(3) Paying the participating physician or supplier directly.

(4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent.

(5) Paying user fees for claim notices that are transmitted electronically or otherwise.

(6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(b) Compliance with the requirements set forth in subsection (a) shall be certified on the Medicare supplement insurance experience reporting form. *(Department of Insurance; 760 IAC 3-10-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2573; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 11. Loss Ratio Standards and Refund or Credit of Premium

760 IAC 3-11-1 Loss ratio standards and refund or credit of premium

Authority: IC 27-8-13-10; IC 27-8-13-12
Affected: IC 27-8-13-1

Sec. 1. (a) Loss ratio standards are as follows:

(1) A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(A) at least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(B) at least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For policies issued any time prior to January 1, 1992, expected claims in relation to premiums shall meet the following:

(A) The originally filed anticipated loss ratio when combined with the actual experience since inception.

(B) The appropriate loss ratio requirement from subdivision (1) when combined with actual experience beginning with April 1, 1996, to date.

(C) The appropriate loss ratio requirements from subdivision (1) over the entire future period for which the rates are computed to provide coverage.

(D) In meeting the tests in clauses (A) through (C) and for purposes of attaining credibility, an issuer may combine experience under policy forms that provide substantially similar coverage. Once a combined form is adopted, the issuer may not separate the experience except with the approval of the commissioner.

(b) Refund or credit calculation is as follows:

(1) An issuer shall collect and file with the commissioner of the department of insurance by May 31 of each year the data contained in the applicable reporting form contained in this section for each type in a standard Medicare supplement benefit plan.

(2) If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For purposes of this section, the issuer of policies or certificates issued prior to January 1, 1992, shall make the refund

or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after April 1, 1996. The first such report shall be due by May 31, 1998.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(c) An issuer of Medicare supplement policies and certificates issued before or after the effective date of this article in this state shall file annually its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner of the department of insurance in accordance with the filing requirements and procedures prescribed by the commissioner of the department of insurance. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio, which is greater than or equal to the applicable percentage, shall be demonstrated for policies or certificates in force less than three (3) years.

(d) As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner of the department of insurance, in accordance with the applicable filing procedures of this state, the following:

(1) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment shall accompany the filing.

(2) An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment, which would modify the loss ratio experience under the policy other than the adjustments described in this subdivision, shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(3) If an issuer fails to make premium adjustments acceptable to the commissioner of the department of insurance, the commissioner of the department of insurance may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by this section.

(4) Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(e) The commissioner of the department of insurance may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this article if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the commissioner of the department of insurance.

(f) The following forms shall be used for the calculations and reporting requirements of this rule:

MEDICARE SUPPLEMENT REFUND CALCULATION FORM

FOR CALENDAR YEAR _____

TYPE[1] _____	SMSBP[2] _____
For the State of _____	Company Name _____
NAIC Group Code _____	NAIC Company Code _____
Address _____	Person Completing Exhibit _____
Title _____	Telephone Number _____

	(a) Earned	(b) Incurred

Line	Premium[3]	Claims[4]
1. Current Year's Experience		
a. Total (all policy years)		
b. Current year's issues[5]		
c. Net (for reporting purposes = 1a - 1b)	_____	_____
2. Past Years' Experience (All Policy Years)	_____	_____
3. Total Experience (Net Current Year + Past Year's Experience)	_____	_____

4. Refunds Last Year (Excluding Interest) _____

5. Previous Since Inception (Excluding Interest) _____

6. Refunds Since Inception (Excluding Interest) _____

7. Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1) _____

8. Experienced Ratio Since Inception _____

$$\frac{\text{Total Actual Incurred Claims (line 3, col. b)}}{\text{Total Earned Prem. (line 3, col. a) – Refunds Since Inception (line 6)}} = \text{Ratio 2}$$

9. Life Years Exposed Since Inception _____

If the Experience Ratio is less than the Benchmark Ratio, and there are more than five hundred (500) life years exposure, then proceed to calculation of refund.

10. Tolerance Permitted (obtained from credibility table)_____

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000–9,999	5.0%
2,500–4,999	7.5%
1,000–2,499	10.0%
500–999	15.0%

If less than 500, no credibility.

MEDICARE SUPPLEMENT REFUND CALCULATION FORM

FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____

For the State of _____ Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____ Person Completing Exhibit _____

Title _____ Telephone Number _____

11. Adjustment to Incurred Claims for Credibility _____

Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.

If Ratio 3 is less than the Benchmark Ratio, then proceed.

12. Adjusted Incurred Claims _____

[Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6)] × Ratio 3 (line 11)

13. Refund = Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6).

Adjusted Incurred Claims (line 12)
Benchmark Ratio (Ratio 1)

If the amount on line 13 is less than.005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

[1] Individual, group, individual Medicare Select, or group Medicare Select only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan.

[3] Includes Modal Loadings and Fees Charged.

[4] Excluded Active Life Reserves.

[5] This is to be used as "Issue Year Earned Premium" for Year 1 of the next year's "Worksheet for Calculation of Benchmark Ratios".

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature

Name–Please Type

Title

Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____

For the State of _____ Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____ Person Completing Exhibit _____

Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)×(c)	Cumulative Loss Ratio	(d)×(e)	Factor	(b)×(g)	Cumulative Loss Ratio	(h)×(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88

10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

[3] Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

[5] These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____

For the State of _____ Company Name _____

NAIC Group Code _____ NAIC Company Code_____

Address _____ Person Completing Exhibit _____

Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)×(c)	Cumulative Loss Ratio	(d)×(e)	Factor	(b)×(g)	Cumulative Loss Ratio	(h)×(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

[3] Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

[5] These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(Department of Insurance; 760 IAC 3-11-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2573; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3419; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 12. Filing and Approval of Policies and Certificates and Premium Rates

760 IAC 3-12-1 Filing and approval of policies and certificates and premium rates

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1; IC 27-8-13-12
Affected: IC 27-8-13-1

Sec. 1. (a) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner of the department of insurance in accordance with filing requirements and procedures prescribed by the commissioner of the department of insurance.

(b) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner of the department of insurance in accordance with the filing requirements and procedures prescribed by the commissioner of the department of insurance.

(c) Except as provided in subsection (d), an issuer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(d) An issuer may offer, with the approval of the commissioner of the department of insurance, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) for each of the following cases:

(1) The inclusion of new or innovative benefits.

(2) The addition of either direct response or agent marketing methods.

(3) The addition of either guaranteed issue or underwritten coverage.

(4) The offering of coverage to individuals eligible for Medicare by reason of disability.

(e) As used in this section, "type" means:

(1) an individual policy;

(2) a group policy;

(3) an individual Medicare select policy; or

(4) a group Medicare select policy.

(f) Except as provided in subdivision (1), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this article that has been approved by the commissioner of the department of insurance. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months and as follows:

(1) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner of the department of insurance in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner of the department of insurance, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(2) An issuer that discontinues the availability of a policy form or certificate form under subdivision (1) shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the commissioner of the department of insurance of the discontinuance. The period of discontinuance may be reduced if the commissioner of the department of

insurance determines that a shorter period is appropriate.

(g) For purposes of subsection (f), this subsection, and subsection (h), the sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance.

(h) A change in the rating structure or methodology shall be considered a discontinuance under subsection (f) unless the issuer complies with the following requirements:

(1) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner of the department of insurance, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(2) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner of the department of insurance may approve a change to the differential which is in the public interest.

(i) Except as provided in subsection (j), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in 760 IAC 3-11.

(j) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation. *(Department of Insurance; 760 IAC 3-12-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2580; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3430; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 13. Permitted Compensation Arrangements

760 IAC 3-13-1 Permitted compensation arrangements

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 1. (a) An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(b) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

(c) No issuer or other entity shall provide compensation to its agents or other producers, and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

(d) No issuer or other entity shall provide to its agents or other producers, and no agent or producer shall receive:

(1) compensation for the sale of a Medicare supplement policy or certificate that differs from the compensation for the sale of any other Medicare supplement policy or certificate because of the level, type, or nature of benefits; or

(2) compensation for the sale of any Medicare supplement policy or certificate to a person that differs from the compensation that applies to the sale of any Medicare supplement policy or certificate to any other person because of the age, health status, claims experience, receipt of health care, or medical condition of that person.

(e) As used in this section, "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including, but not limited to, the following:

(1) Bonuses.
(2) Gifts.
(3) Prizes.
(4) Awards.
(5) Finders fees.

(Department of Insurance; 760 IAC 3-13-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2581; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3430; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1977; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 14. Required Disclosure Provisions

760 IAC 3-14-1 Required disclosure provisions

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1; IC 27-8-13-12; IC 27-8-13-14; IC 27-8-13-15; IC 27-8-13-16
Affected: IC 27-8-13-1

Sec. 1. (a) General provisions are as follows:

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision shall be consistent with the type of contract issued. Such provision shall be appropriately captioned, appear on the first page of the policy, and include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations".

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6) Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare (Guide) in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12-point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this article. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application, and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request, but not later than at the time the policy is delivered.

As used in this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(b) Notice requirements are as follows:

(1) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner of the department of insurance. Such notice shall do the following:

(A) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate.

(B) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) Such notices shall not contain or be accompanied by any solicitation.

(c) The outline of coverage requirements for Medicare supplement policies are as follows:

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of such outline from the

applicant.

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.".

(3) The outline of coverage provided to applicants under this section consists of the following:

(A) The cover page described in subsection (e).

(B) Premium information on or immediately following the cover page.

(C) Disclosure pages described in subsection (f).

(D) Charts displaying the features of each benefit plan offered by the issuer described in subsection (g).

The outline of coverage shall be in the language and format prescribed in subsections (e) through (g) in no less than 12-point type. Plans A through J, described in 760 IAC 3-7, shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(d) The following are notices regarding policies or certificates that are not Medicare supplement policies:

(1) Any:

(A) accident and sickness insurance policy or certificate, other than a Medicare supplement policy;

(B) policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. 1395 et seq.);

(C) disability income policy; or

(D) other policy identified in 760 IAC 3-1-1(b);

issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy or, if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.".

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subdivision (1) shall disclose, using the applicable statement in this subdivision, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as part of, or together with, the application for the policy or certificate. The following instructions and forms shall be used for the disclosure statement regarding duplication of Medicare:

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for
Health Insurance Policies Sold to Medicare Beneficiaries
that Duplicate Medicare

1. Section 1882(d) of the federal Social Security Act, 42 U.S.C. 1395ss, prohibits the sale of a health insurance policy (the term policy or policies includes certificates) that duplicates Medicare benefits unless it will pay benefits without regard to other health coverage and it includes the prescribed disclosure statement on or together with the application.

2. All types of health insurance policies that duplicate Medicare shall include one (1) of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement.

4. Property/casualty and life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. Long term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

7. The federal law does not pre-empt state laws that are more stringent than the federal requirements.
8. The federal law does not pre-empt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended to allow for alternative disclosure statements. Carriers may use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

*****

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

*****

[Original disclosure statement for policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense incurred cancer, specified disease, and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one (1) of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

*****

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

*****

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one (1) of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

*****

[Original disclosure statement for policies that provide benefits for both expenses incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

*****

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductible or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

*****

[Original disclosure statement for other health insurance policies not specifically identified in the previous statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

*****

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

*****

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.
This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

*****

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease, and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.
This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one (1) of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

*****

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.
This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one (1) of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

*****

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.
This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

*****

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.
This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items & services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

*****

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.
This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

*****

(e) The cover page of the outline described in subsection (c) shall be in the format as follows:

(COMPANY NAME)

Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plan(s) _____(insert letter(s) of plan(s) being offered)

Medicare supplement insurance can be sold in only ten standard plans, plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some of the other plans may not be available from every company.

Basic Benefits: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare approved expenses).

Blood: First three pints of blood each year.

A	B	C	D	E	F / F*	G	H	I	J / J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Basic Drugs ($3,000 Limit)
				Preventive Care					Preventive Care

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year [$1,500] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plans' separate foreign travel emergency deductible.

(f) The following items shall be included in the outline of coverage in the order prescribed:

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when the premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.
RIGHT TO RETURN POLICY [Boldface Type]
If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.
POLICY REPLACEMENT [Boldface Type]
If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.
NOTICE [Boldface Type]
The policy may not fully cover all of your medical costs.
[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.
[for direct response:]
[insert company's name] is not connected with Medicare.
This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "The Medicare Handbook" for more details.
COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]
When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]
Review the application carefully before you sign it. Be certain that all information has been properly recorded.

(g) The NAIC Model Laws, Regulations and Guidelines, Vol. IV, pages 651-40 through 651-67, Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (April 1998) are hereby incorporated by reference as if fully set out herein as the format for the charts described in subsection (c), except that on page 651-59, the Part B excess charges benefits for Plan "H" medical expenses is changed from eighty percent (80%) to zero (0) in the "Plan Pays" column. *(Department of Insurance; 760 IAC 3-14-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2581; errata filed Sep 20, 1993, 5:00 p.m.: 17 IR 200; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3431; errata filed Sep 24, 1996, 10:30 a.m.: 20 IR 332; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1978; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 15. Requirements for Application Forms and Replacement Coverage

760 IAC 3-15-1 Application forms and replacement coverage

Authority: IC 27-8-13-10; IC 27-8-13-16
Affected: IC 27-8-13-1

Sec. 1. (a) Application forms shall include statements and questions as established in this subsection designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing questions and statements may be used, such as the following:

(1) The following statements:

(A) You do not need more than one (1) Medicare supplement policy.

(B) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(C) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(D) The benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within ninety (90) days of losing Medicaid eligibility.

(E) Counseling services may be available in your state to provide advice concerning your purchase of Medicare

supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

(2) The following questions:

(A) To the best of your knowledge:

(i) Do you have another Medicare supplement policy or certificate in force?

(AA) If so, with which company?

(BB) If so, do you intend to replace your current Medicare supplement policy with this policy [certificate].

(ii) Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

(AA) If so, with which company?

(BB) What kind of policy?

(iii) Are you covered for medical assistance through the state Medicaid program:

(AA) As a Specified Low-Income Medicare Beneficiary (SLMB)?

(BB) As a Qualified Medicare Beneficiary (QMB)?

(CC) For other Medicaid medical benefits?

(b) Agents shall list any other health insurance policies they have sold to the applicant. List policies sold:

(1) that are still in force; and

(2) in the past five (5) years that are no longer in force.

(c) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

(d) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(e) The notice required by subsection (d) for an issuer shall be provided in substantially the following form in no less than 12-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplemental coverage. The replacement policy is being purchased for the following reasons (check one):

____ Additional benefits.

____ No change in benefits, but lower premiums.

____ Fewer benefits and lower premiums.

____ Other (please specify)._____

_____

_____

_____

(1) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods,

elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.
(2) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)
Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.
(Signature of Agent, Broker or Other Representative)*
[Typed Name and Address of Issuer, Agent or Broker]
(Applicant's Signature)
(Date)
*Signature not required for direct response sales.

(f) Subsection (e)(1) and (e)(2) of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation. *(Department of Insurance; 760 IAC 3-15-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2615; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3464; errata filed Sep 24, 1996, 10:30 a.m.: 20 IR 332; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 16. Filing Requirements for Advertising

760 IAC 3-16-1 Filing requirements for advertising

Authority: IC 27-8-13-10
Affected: IC 27-8-13-18

Sec. 1. An issuer shall file a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, or television media to the commissioner of the department of insurance of this state. *(Department of Insurance; 760 IAC 3-16-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2616; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 17. Standards for Marketing

760 IAC 3-17-1 Marketing

Authority: IC 27-8-13-10, IC 27-8-13-16
Affected: IC 27-4-1-4; IC 27-8-13-1

Sec. 1. (a) An issuer, directly or through its producers, shall do the following:
(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.
(2) Establish marketing procedures to assure excessive insurance is not sold or issued.
(3) Establish marketing procedures which set forth a mechanism or formula for determining whether a replacement policy or certificate is truly in the best interest of the applicant.
(4) Display prominently by type, stamp, or other appropriate means, on the first page of the policy, the following:
"Notice to buyer: This policy may not cover all of your medical expenses.".
(5) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.
(6) Establish auditable procedures for verifying compliance with this subsection.
(b) In addition to the practices prohibited in IC 27-4-1-4, the following acts and practices are prohibited:
(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(c) The terms "Medicare supplement", "Medigap", "Medicare wrap-around", and words of similar import shall not be used unless the policy is issued in compliance with this article. *(Department of Insurance; 760 IAC 3-17-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2616; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 18. Recommended Purchase and Excessive Insurance

760 IAC 3-18-1 Appropriateness of recommended purchase and excessive insurance; reporting of multiple policies

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1; IC 27-8-13-12
Affected: IC 27-8-13

Sec. 1. (a) In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) Any sale of Medicare supplement coverage that will provide an individual more than one (1) Medicare supplement policy or certificate is prohibited, except that an agent may sell a replacement policy or certificate in accordance with 760 IAC 3-1-15 *[sic.]* provided that the replacement policy or certificate is not made effective any sooner than is necessary to provide continuous benefits for preexisting conditions.

(c) An insurer which issues a Medicare supplement policy or certificate to any individual who has one (1) policy or certificate then in effect, except as permitted by subsection (b), shall, at the request of the insured, either refund the premiums or pay any claims on the policy or certificate, whichever is greater.

(d) On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one (1) Medicare supplement policy or certificate:

(1) Policy and certificate number.

(2) Date of issuance.

(e) The items set forth in subsection (d) must be grouped by individual policyholder.

(f) The form for reporting the information required by subsection (d) is as follows:

FORM FOR REPORTING
MEDICARE SUPPLEMENT MULTIPLE POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one (1) Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

(Department of Insurance; 760 IAC 3-18-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2617; errata filed Sep 20, 1993, 5:00 p.m.: 17 IR 200; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1987; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 19. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods, and Probation Periods

760 IAC 3-19-1 Prohibition against preexisting conditions, waiting periods, elimination periods, and probationary periods in replacement policies or certificates

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 1. (a) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

(b) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods. *(Department of Insurance; 760 IAC 3-19-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2618; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 20. Separability

760 IAC 3-20-1 Separability

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 1. If any provision of this article or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the article and the application of such provision to other persons or circumstances shall not be affected thereby. *(Department of Insurance; 760 IAC 3-20-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2618; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

*