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Organization and Rules of Practice

ARTICLE I

DESCRIPTION OF ORGANIZATION AND PUBLIC INFORMATION

Sec. 38a-8-1. Duties and authority of insurance department

The mission of the Insurance Department is to serve consumers in a professional and timely manner by providing assistance and information to the public and to policy makers, by regulating the insurance industry in a fair, flexible and efficient manner that promotes a competitive and financially sound insurance market for consumers, and by enforcing the insurance laws to ensure that consumers are treated fairly and are protected from unfair practices. The Insurance Department shall act on the Insurance Commissioner's behalf and at his or her direction to fulfill the Commissioner's responsibilities under Title 38a of the Connecticut General Statutes. As such, the insurance department's duties and authority are primarily set out in Title 38a of the Connecticut General Statutes. It is the primary function of the Insurance Department to see that all laws regarding insurance are complied with and that the public interest is protected by the enforcement of the insurance laws and all implementing regulations.

(Effective September 25, 1992; amended February 1, 2001, September 9, 2008)

Sec. 38a-8-2. Basic organization

The Insurance Department consists of the office of the Commissioner and seven divisions which are as follows:

(1) Administration Division — responsible for all functions relating to accounting, budget and fiscal services, payroll and personnel procedures, and computer support for the Insurance Department.

(2) Legal Division — in consultation with the Office of the Attorney General, provides legal advice and related services to the Commissioner and each division of the Insurance Department. The division also provides oversight of insurance company receiverships and insurance guaranty associations.

(3) Financial Regulation Division — consists of three units: the Financial Analysis Unit; the Financial Examinations Unit; and the Financial Actuarial Unit. (A) The Financial Analysis Unit determines the eligibility of insurance companies applying for a certificate of authority to do an insurance business in Connecticut, and monitors the financial condition of admitted domestic and foreign insurance companies, health care centers, fraternal benefit societies and eligible surplus lines insurers through the analysis of financial statements, and other information required by statute. (B) The Financial Examinations Unit conducts on-site financial examinations of domestic entities to ensure that such entities remain solvent and capable of meeting their contractual obligations to policyholders and claimants. (C) The Financial Actuarial Unit participates in the financial analysis and the financial examinations of domestic insurance entities to ensure the ongoing solvency of such entities.

(4) Life and Health Division — reviews all group and individual life and health insurance policies and rates of licensed insurance companies, fraternal benefit societies, hospital or medical corporations, and health care centers as required by statute. Approves all such policies prior to being offered in Connecticut. Approves rates for health care center subscriber agreements, individual accident and health policies, Medicare supplement policies and individual long-term care policies. Rates for group long-term care policies shall be filed and are subject to disapproval by the Commissioner. Approves deviations from the prima facie rates for credit life and

health. Licenses utilization review companies. Publishes annual comparison of managed care organizations.

(5) **Division of Rate Review - Property and Casualty** — examines property and casualty rates, rules, policy forms and underwriting guidelines to ensure that insurance products sold in Connecticut by licensed companies comply with statutory requirements. Reviews rates of residual market providers including the Workers' Compensation Assigned Risk Plan, the Connecticut Automobile Insurance Assigned Risk Plan, and the Fair Access to Insurance Requirements Plan. Licenses and examines rating, advisory and joint underwriting organizations and self-insured pools and plans.

(6) **Licensing Division** — ensures that only competent and trustworthy persons are licensed to perform insurance services in Connecticut through the determination of eligibility of persons seeking licensure to act as an insurance producer, surplus lines broker, public adjuster, casualty adjuster, motor vehicle physical damage appraiser, fraternal agent, certified insurance consultant, bail bonds agent, viatical settlement provider, viatical settlement investment agent, viatical settlement broker, and reinsurance intermediary. Administers a program of continuing education for insurance producers in order to make certain that all Connecticut producers continue to remain informed of insurance industry issues and trends as well as Connecticut statutory and regulatory changes.

(7) **Consumer Affairs Division** — consists of three units: the Consumer Services Unit; the Market Conduct Unit; and the Insurance Fraud Unit. (A) The Consumer Services Unit receives and reviews complaints from residents of Connecticut concerning their insurance problems, including claims disputes, serves as a mediator in such disputes in order to determine whether statutory and contractual obligations have been fulfilled, and administers external grievance process and oversees expedited review process for managed care plans. Provides an independent arbitration procedure for: (i) the settlement of disputes between claimants and insurance companies concerning automobile physical damage and automobile property damage liability claims in which liability and coverage are not in dispute; and (ii) the resolution of disputes arising arising out of extended warranty contracts. (B) The Market Conduct Unit examines the affairs and conduct of insurance companies, health care centers, fraternal benefit societies and medical utilization review companies authorized to do business in Connecticut, for the purpose of analyzing the treatment of Connecticut policyholders and claimants. Investigates and prosecutes alleged infractions of licensing laws pertaining to individuals or organizations, and allegations of fraud. (C) The Insurance Fraud Unit staff receives, gathers and reports data on patterns of insurance fraud in Connecticut, and develops and provides outreach programs implemented to aid the public in recognizing, avoiding and reporting suspected insurance fraud.

(Effective September 25, 1992; amended February 1, 2001, September 9, 2008)

Sec. 38a-8-3. Duties and method of operations

(a) **Commissioner.** The Insurance Commissioner is the department head in accordance with section 4-5 of the Connecticut General Statutes and administers the provisions of Title 38a in accordance with section 4-8 of the Connecticut General Statutes. In carrying out his or her official duties, the Commissioner may delegate his or her authority to a deputy commissioner, chief of staff, a division of the department, an individual division director, a hearing officer or an examiner when appropriate. Such person shall serve as his or her designee at the pleasure of the Commissioner.

(b) **Administration Division.** The Administration Division:

- (1) maintains accounting records of department;
 - (2) prepares and maintains payroll records for department;
 - (3) prepares budget for department;
 - (4) is responsible for mail, supplies, and other related support activities;
 - (5) processes receipts from fees collected from insurers and producers;
 - (6) processes taxes collected from surplus lines brokers and unauthorized insurers;
 - (7) maintains staff recruitment, classification and compensation;
 - (8) administers collective bargaining contracts;
 - (9) administers personnel policy and procedures, investigates complaints of misconduct;
 - (10) administers grievances;
 - (11) processes time and attendance for department;
 - (12) provides information technology support; and
 - (13) performs other related duties as assigned by the Commissioner.
- (c) **Financial Regulation Division.** The Financial Regulation Division:
- (1) examines, reviews and analyzes the affairs and records of all insurance companies, fraternal benefit societies, health care centers, nonprofit hospital and medical service corporations, interlocal risk management agencies, employers' mutual associations, and life insurance departments of savings banks for solvency and compliance with applicable statutes, and issues appropriate licenses to conduct business in this state;
 - (2) reviews all applications submitted by domestic and foreign insurance companies and fraternal benefit societies and health care centers that desire to become licensed in this state;
 - (3) verifies, annually, the life insurance reserves held by all Connecticut chartered life insurance companies;
 - (4) receives and reviews registration statements as well as receives, reviews and approves or disapproves material transactions of insurance companies that are part of a holding company system;
 - (5) receives and reviews applications from insurance companies involved in mergers and tender offers;
 - (6) maintains records of insurance companies licensed in Connecticut and furnishes information regarding status of companies;
 - (8) licenses preferred provider networks and viatical settlement companies; and
 - (9) performs other related duties as assigned by the Commissioner.
- (d) **Life and Health Division.** The Life and Health Division:
- (1) accepts for filing, and approves or disapproves, all life and accident and health policy forms that licensed insurance companies, fraternal benefit societies, hospital or medical service corporations, and health care centers intend to sell in this state, and all contracts and disclosure statements that viatical settlement companies intend to use in the state, and approves or disapproves health care center, individual accident and health, credit life and health, individual long-term care, and Medicare supplement premium rates. Accepts for filing and has authority to disapprove group long-term care premium rates;
 - (2) accepts for filing reporting requirements, publishes report card, oversees contracting of vendors for expedited review process and external grievance process for managed care organizations;
 - (3) licenses utilization review companies; and
 - (4) performs other related duties as assigned by the Commissioner.
- (e) **Division of Rate Review - Property and Casualty.** The Division of Rate Review - Property and Casualty:

(1) reviews and accepts or disapproves all policy forms, endorsements, rules, rates, and rating plans used by property and casualty insurance companies involving all lines of property and casualty insurance;

(2) licenses rating and advisory organizations, and, in addition, periodically examines the affairs of such organizations;

(3) approves statistical plans of insurers or rating organizations for the recording and reporting of loss and expense experience;

(4) investigates complaints involving rates and rating plans as well as complaints about individual policies;

(5) supervises the Connecticut Fair Plan, Workers' Compensation Assigned Risk Plan, the Connecticut Automobile Insurance Assigned Risk Plan and approves rates, rules, forms, and rating plans to be used therein;

(6) approves the forms, rules, rates, and administration of the Connecticut Fair Plan to determine that fire insurance is available to all Connecticut residents at a reasonable cost; and

(7) performs other related duties as assigned by the Commissioner.

(f) Licensing Division.

The Licensing Division:

(1) issues the following licenses:

(A) insurance producers, under chapter 701a and chapter 702, part II, of the Connecticut General Statutes;

(B) public adjusters, under chapter 701b and chapter 702, part IV, of the Connecticut General Statutes;

(C) reinsurance intermediaries, under chapter 701e of the Connecticut General Statutes;

(D) casualty claim adjusters, under chapter 702, part VI, of the Connecticut General Statutes;

(E) surplus lines brokers, under chapter 701d and chapter 702, part VII, of the Connecticut General Statutes;

(F) fraternal agents, under chapter 701f and chapter 702, part IX, of the Connecticut General Statutes;

(G) motor vehicle physical damage appraisers, under chapter 702, part VI, of the Connecticut General Statutes;

(H) certified insurance consultants under chapter 701c and chapter 702, part III, of the Connecticut General Statutes;

(I) insurance premium finance companies, under the provisions of chapter 698, part VII, of the Connecticut General Statutes; and

(J) viatical settlement brokers and investment agents under chapter 700b of the Connecticut General Statutes;

(2) issues to applicants and insurers instructions regarding eligibility requirements necessary for the type of license applied for, in accordance with the statutes cited; and

(3) determines the qualification of applicants with due regard to the public interest and coordinates and administers qualifying examinations as required by the cited statutes.

(g) Consumer Affairs Division. (1) The Consumer Services Unit receives, reviews and responds to complaints and inquiries from state residents concerning insurance related problems. The staff examines each complaint to determine whether statutory requirements and contractual obligations within the commissioner's jurisdiction have been fulfilled. The Consumer Services Unit coordinates the resources available within the department to fully address consumer complaints. (2) The Market Conduct Unit investigates complaints against all licensees; prepares cases

for presentation at department hearings; enforces compliance with licensing laws and regulations and other laws with the provisions of Title 38a of the Connecticut General Statutes. (3) The Insurance Fraud Unit receives information, analyzes and reports data relating to insurance fraud in Connecticut; provides education to the public on how to recognize, avoid and report insurance fraud and licenses medical discount plans and pharmacy benefit managers.

(h) **Legal Division.** The Legal Division provides legal advice and related services to the Commissioner and the seven divisions of the Insurance Department on a broad spectrum of issues that arise in regulating the insurance industry and in providing services to the consumer. In doing so, the legal staff of this office drafts, monitors and analyzes legislation; drafts and promulgates regulations; and participates in department hearings involving rates, license enforcement, and acquisitions of domestic insurance companies. The legal division also manages insurance company receiverships on behalf of the Commissioner upon his or her appointment by the Superior Court as receiver and provides oversight of the insurance guaranty associations and in doing so, keeps the staff of the consumer affairs division, and other department staff, informed on developments so they may properly service the inquiries and complaints of consumers.

(Effective September 25, 1992; amended February 1, 2001, September 9, 2008)

Sec. 38a-8-4. Location of principal office

The Insurance Department is located at 153 Market Street (960 Main Building), 7th Floor, Hartford, Connecticut 06103. The Insurance Department's mailing address is P.O. Box 816, Hartford, Connecticut 06142-0816. Normal business hours are from 8:00 a.m. to 5:00 p.m. daily except Saturdays, Sundays, and holidays.

(Effective September 25, 1992; amended February 1, 2001, September 9, 2008)

Sec. 38a-8-5. Public information

The policy of the Insurance Department, in accordance with the Freedom of Information Act, chapter 14 of the Connecticut General Statutes, is to make available for public inspection all files, records, and documents and other materials within its possession, unless prohibited by law.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-6. Insurance department bulletins

Any person or group may file a request with the Commissioner to be placed on a mailing list to receive Insurance Department Bulletins. Such request shall be in effect only for the calendar year in which it was filed and all requests shall expire on December 31 each year. The fee for being placed on the mailing list for all Insurance Department Bulletins shall be \$20.00 per year and each request shall be accompanied by a check or money order payable to the Treasurer, State of Connecticut.

(Effective September 25, 1992; amended February 1, 2001)

ARTICLE II

SCOPE AND CONSTRUCTION OF RULES

Part I

General Provisions

Sec. 38a-8-7. Procedure governed

Section 38a-8-7 to section 38a-8-75, inclusive, of the Regulations of Connecticut State Agencies govern practice and procedure before the Insurance Commissioner or any division of the Insurance Department, an individual division head or a hearing

officer, under the applicable laws of the State of Connecticut, and except where by statute otherwise provided.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-8. Definitions

(a) As used in section 38a-8-1 to section 38a-8-75, inclusive, of the Regulations of Connecticut State Agencies, the following words and phrases shall have the same definitions as those contained in chapter 54 of the Connecticut General Statutes: “contested case,” “final decision,” “hearing officer,” “intervenor,” “license,” “party,” “person,” “presiding officer,” “proposed final decision,” “proposed regulation,” “regulation,” and “regulation-making.”

(b) In addition, as used in section 38a-8-1 to section 38a-8-75, inclusive, of the Regulations of Connecticut State Agencies, the following words and phrases shall have the following meanings, except where any such word or phrase is used in a context which clearly indicates the contrary:

(1) “Appellant” means a person who takes an appeal to the Insurance Commissioner from a decision or ruling of the manager or committee designated to operate a residual market mechanism;

(2) “Applicant” means a party applying for any license, right or authority from the Insurance Commissioner;

(3) “Commissioner” means the Insurance Commissioner;

(4) “Complainant” means any person who complains to the Insurance Commissioner of any alleged act or omission in violation of insurance law, regulations or order of the Insurance Commissioner;

(5) “Hearing” means that portion of the department’s procedures in the disposition of matters delegated to its jurisdiction by law wherein an opportunity, as deemed appropriate by the presiding officer, for presentation of evidence and argument occurs;

(6) “Non conforming” means not in compliance with applicable provisions of the General Statutes or implementing regulations;

(7) “Petitioner” means a person who has filed a petition with the Insurance Department seeking relief from the Insurance Commissioner;

(8) “Residual market mechanism” means an association, organization or other entity defined or described in sections 38a-328, 38a-329 and 38a-670 of the Connecticut General Statutes;

(9) “Respondent” means a person against whom an order or a proceeding is directed; and

(10) “Rules of practice” means section 38a-8-7 to section 38a-8-75, inclusive, of the Regulations of Connecticut State Agencies.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-9. Waiver of rules

Where good cause appears, the Commissioner or any presiding officer may permit deviation from the rules of practice, except where precluded by law.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-10. Construction and amendment

The rules of practice shall be construed by the Commissioner and any presiding officer as to secure just, speedy, and inexpensive determination of the issues presented hereunder. Amendments and additions to the rules of practice may be adopted by the Commissioner by being duly promulgated as regulations in accordance with Chapter 54 of the Connecticut General Statutes.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-11. Computation of time

Computation of any period of time referred to in the rules of practice begins with the first day following that on which the act which initiates such period of time occurs and ends on the last day of the period so computed. This last day of that period is to be included unless it is a day on which the office of the department is closed, in which event the period shall run until the end of the next following business day. When such period of time, with the intervening Saturdays, Sundays, and legal holidays counted, is five (5) days or less, such Saturdays, Sundays, and legal holidays shall be excluded from the computation; otherwise such days shall be included in the computation.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-12. Extension of time

In the discretion of the Commissioner, or the presiding officer, for good cause shown any time limit prescribed or allowed by the rules of practice may be extended. All requests for extensions shall be made before the expiration of the period originally prescribed or as previously extended. The Commissioner shall cause all parties to be notified of the action upon any such motion.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-13. Effect of filing

(a) The filing with the department of any application, petition, complaint, request for declaratory ruling or any other filing of any nature whatsoever shall not relieve any person of the obligation to comply with any statute, regulation or order of the Commissioner.

(b) Unless the Commissioner provides otherwise in writing, accepting the filing of any non-conforming petition, application, exhibit, annex or document of any kind whatsoever, shall not be construed as a waiver of compliance with these rules.

(c) Any petition or application filed for the purpose of securing from the Commissioner an approval or grant of permission under the rules of practice and any supporting evidence annexed or filed as part of such petition or application shall be part of the public records of the department as defined by section 1-200 of the Connecticut General Statutes, except when expressly excluded by the provisions of section 1-210(b) of the Connecticut General Statutes, or other statutes. Such public record shall include and not be limited to all written forms, required components, pre-filed testimony, exhibits, and other evidence attached to the application as part thereof.

(Effective September 25, 1992; amended February 1, 2001)

Part 2**Formal Requirements****Sec. 38a-8-14. Date of filing**

All orders, decisions, findings of fact, correspondence, motions, petitions, applications, and any other documents governed by the rules of practice, including rate applications and applications for approval as hereinafter defined, shall be deemed to have been filed or received on the date on which they are issued or received by the department or the Commissioner at its principal office, except as hereinafter provided.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-15. Identification of communications

Communications should embrace only one matter and shall contain the name and address of the sender and an appropriate file reference to the subject of the

communication. When the subject matter pertains to a proceeding pending before the insurance department, the title of the proceeding and the department docket number should be given.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-16. Signatures

Every application, notice, motion, petition, brief, memorandum and other communications shall be signed by the filing person or by one or more attorneys in their individual names on behalf of the filing person.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-17. Formal requirements as to documents and other papers filed in proceedings

(a) **Copies.** Except for routine correspondence and inquiries by the public, and as may be otherwise required by the rules of practice or by any other rules or regulations of the Commissioner or as ordered or expressly requested by the Commissioner, at the time motions, petitions, applications, documents or other papers are filed with the Commissioner, there shall be furnished to the Commissioner the original of such papers. In addition to the original, there shall also be filed four (4) copies for the use of the department, the staff, and the public, unless a greater or lesser number of such copies is expressly requested by the Commissioner.

(b) **Form.** Except for such forms as may from time to time be provided or adopted by the department and used where appropriate, all documents and papers including but not limited to motions, petitions, applications, notices, briefs, exhibits, and all other written materials filed for the purpose of any proceeding before the department shall be on only one side of eight and one half by eleven inch (8¹/₂" × 11") paper, unless pre-printed, and shall be double spaced. Reproduced copies of the original documents will be accepted provided all copies filed are clear and permanently legible.

(c) **Filing.** All motions, petitions, applications, documents or other papers relating to matters requiring action by the Commissioner or the department shall be filed with the Commissioner, at the Department's principal office.

(d) Failure to comply with the provisions of this section shall constitute a deficiency in filing and as such shall be subject to the regulations governing that contingency.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-18. Service

(a) **General rule.** Service of all documents and other papers filed in all contested cases, including but not limited to motions, petitions, applications, notices, briefs, and exhibits shall be by personal delivery, first class mail or other manner as determined by the Commissioner, except as otherwise provided by law.

(b) **On whom served.** In addition to the filing of such documents and papers by the person filing an original plus four (4) copies on the Commissioner, one copy shall be served by personal delivery, first class mail or other manner as determined by the Commissioner on every person that has theretofore been designated a party or intervenor in the proceeding. Certification of such service shall be endorsed on all documents and other papers when filed with the Commissioner.

(c) **Service by the Commissioner.** A copy of any documents or other papers served by the Commissioner showing the addresses to whom the document or other

paper was mailed and the date of mailing shall be placed in the department's files and shall be prima facie evidence of such service and the date thereof.

(d) **Service as written notice.** Written notice of all orders, decisions or authorizations, issued by the Commissioner, shall be given to the party affected thereby and to such other person as the Commissioner may deem appropriate by personal service upon such person, first class mail or other manner determined by the Commissioner.

(Effective September 25, 1992; amended February 1, 2001)

ARTICLE III REQUIREMENTS FOR APPLICATIONS AND PETITIONS

Part I

General Provisions

Sec. 38a-8-19. General rule

Petitions and applications shall include all proposals, requests, applications, petitions, and filings of whatever nature that are placed before the Commissioner or the Insurance Department pursuant to law including, but not limited to, petitions for declaratory ruling, petitions for regulation, applications for any license, and applications for approval of rates or contracts.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-20. Function of application

The petition or application and annexed materials may be treated by the department as a substantially complete statement of the case in chief of the applicant or petitioner.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-21. Required components, general

(a) **Form.** The form to be followed in the filing of petitions and applications hereunder will vary to the extent necessary to provide for the nature of the legal rights, duties or privileges involved therein. In addition to the special provisions for particular types of petitions and applications provided by the rules of practice, all petitions and applications shall include the following components:

(1) Each petition or application shall incorporate a statement setting forth clearly and concisely the authorization or other relief sought. The statement shall cite by appropriate reference the statutory provision or other authority under which such authorization or relief is to be granted by the Commissioner.

(2) The exact legal name of each person seeking the authorization or relief and the address or principal place of business of each such person. If any applicant or petitioner is a corporation, trust association or other organized group, it shall also give the state under the laws of which it was created or organized.

(3) The name, title, address and telephone number of the attorney or other person to whom correspondence or communications in regard to the petition or application shall be addressed. Notice, orders and other papers may be served upon the person so named; and such service shall be deemed to be service upon the petitioner or applicant.

(4) A concise and explicit statement of the facts on which the Commissioner is expected to rely in granting the authorization or other relief sought.

(5) An explanation of any unusual circumstances involved in the petition or application to which the Commissioner will be expected to direct particular attention, including the existence of emergency conditions or any request for the granting of interlocutory relief by way of an interim order in the proceeding.

(b) **Annexed materials.** There shall be attached to the petition or application and filed as part thereof any and all exhibits, sworn written testimony, data, models, illustrations and all other materials that the petitioner or applicant deems necessary or desirable to support the granting of the petition or application. In addition, such annexed materials shall also include such exhibits, sworn written testimony, and other data that any statute or the rules of practice may require for the lawful determination of the petition or application.

(c) **Additional evidence submitted.** The enumeration of required items herein set forth as the minimum evidentiary submission shall not preclude the submission of additional evidence with the petition or application.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-22. Original records

When so required, the petitioner or applicant shall furnish and make available for the use of the department the original books, papers, and documents from which any evidence supporting the granting of the petition or application is derived. Failure to furnish records as directed may be grounds for rejecting any component and, if appropriate, for the entry of a decision denying the petition or application.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-23. Fees

(a) All application fees or other charges required or authorized by law shall be paid to the Commissioner by check or money order made payable to the Treasurer, State of Connecticut, at the time that the application is filed, unless otherwise required by law.

(b) Except as otherwise provided by law, if the Commissioner finds that any application received from an applicant does not conform to law, the Commissioner may return it, with any fee that was submitted with it, to the applicant for correction.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-24. Date of filing, components, deficiencies

(a) The date of filing of any application with the department shall be the date that the application is received by the Commissioner.

(b) An application shall consist of all the required components and any special components set forth in the rules of practice.

(c) Any application or petition which is incomplete or not in conformity with the rules of practice may be rejected by the Commissioner.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-25. Reserved

Part 2

Special Provisions

Sec. 38a-8-26. Petition requesting the promulgation, amendment or repeal of regulations

(a) **General.** Any interested person may at any time petition the Commissioner requesting the promulgation, amendment or repeal of a regulation.

(b) **Form.** The petition shall conform to the general provisions of the rules of practice where applicable and, in addition, shall set forth clearly and concisely the text of the proposed regulation or amendment or the provisions sought to be repealed. The petition shall also state the facts and arguments on which the petitioner relies either in the petition or in a brief annexed thereto.

(c) **Decision on petition.** Not more than thirty (30) days after receipt of the petition, the Commissioner shall determine whether to deny the petition or to initiate regulation making proceedings in accordance with law.

(d) **Procedure on denial.** If the Commissioner denies the petition, the Commissioner shall give the petitioner notice in writing, stating the reasons for the denial. (Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-27. Petition for declaratory ruling

(a) **General.** The rules of practice set forth the procedure to be followed by the Commissioner in the disposition of requests for declaratory rulings as to the validity of any regulation, or the applicability of any statutory provision or of any regulation or order of the Commissioner.

(b) **Form of petition for declaratory ruling.** Any person may at any time request a declaratory ruling from the Commissioner with respect to the validity of any regulation, or applicability to such person of any statute, regulation or order enforced, administered or promulgated by the Commissioner. Such request shall be filed in accordance with the applicable provisions of the rules of practice and shall in addition:

(1) state clearly and concisely the substance and nature of the request;

(2) identify the statute, regulation or order concerning which the inquiry is made; and

(3) identify the particular aspect thereof to which the inquiry is directed. The request for an advisory ruling shall be accompanied by a statement of any supporting data, facts, and arguments that support the position of the person making the inquiry.

(c) **Notice to other persons.** The Commissioner may give notice to any person that such a declaratory ruling has been requested and may receive and consider data, facts, arguments, and opinions from persons other than the person requesting the ruling.

(d) **Decision on petition.** Not more than sixty days after receipt of a petition for declaratory ruling, the Commissioner in writing shall:

(1) issue a ruling declaring the validity of a regulation or the applicability of the provision of the general statutes, the regulation or final decision in question to the specified circumstances;

(2) order the matter set for specified proceedings, including a hearing;

(3) agree to issue a declaratory ruling by a specified date;

(4) decide not to issue a declaratory ruling and initiate regulation-making proceedings under sec. 4-168 of the Connecticut General Statutes, on the subject; or

(5) decide not to issue a declaratory ruling, stating the reasons for his or her action.

(e) **Provision for hearing.** If the Commissioner deems a hearing necessary or helpful in determining any issue concerning the request for a declaratory ruling, the Commissioner shall schedule such hearing and give such notice thereof as shall be appropriate. The provisions of Article IV, Parts 1 and 2, of the rules of practice, shall govern the practice and procedure of the Commissioner in any hearing concerning a declaratory ruling.

(f) **Decision on petition, ruling denied.** If the Commissioner determines that a declaratory ruling will not be rendered, the Commissioner shall notify the person so inquiring that the request has been denied not later than thirty (30) days after the Commissioner's determination.

(g) **Decision on petition, ruling granted.** If the Commissioner renders a declaratory ruling, a copy of the ruling shall be sent to the person requesting it and to that person's attorney, if any, and to any other person who has filed a written request for a copy with the Commissioner.

(Effective September 25, 1992; amended February 1, 2001)

Secs. 38a-8-28—38a-8-29. Reserved**ARTICLE IV****HEARINGS****Part I****General Provisions****Sec. 38a-8-30. Calendar of hearings**

The Commissioner shall maintain a docket of all proceedings of the Department. The Commissioner shall maintain a hearing calendar of all proceedings that are to receive a hearing. Proceedings shall be placed on the hearing calendar in the order in which the proceedings are listed on the docket of the department, unless otherwise ordered by the Commissioner. The Department shall maintain a calendar of scheduled hearings. The Department shall give notice by mail of each hearing, at least one week prior to the date set for such hearing, to any person who has filed a written request for such notice with the Department, except that the Department may give notice as it deems practical of hearings called less than seven days prior to the date set for such hearing. Any request for notice filed pursuant to this section shall be valid for one year from the date on which it is filed unless a renewal request is filed. Renewal requests shall be filed within thirty days after January 1 of each year pursuant to section 1-227 of the Connecticut General Statutes. The charge for fulfilling the requests of those persons who have requested written notice of hearings is \$20.00 per year.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-31. Public hearing; hearing location; recording, broadcasting or photographing hearings

(a) Unless otherwise provided by statute, all hearings shall be open to the public.

(b) Unless by statute or by direction of the Commissioner a different place is designated, all hearings of the department shall be held at Hartford at the Office of the Commissioner.

(c) At any public hearing, the Commissioner or presiding officer may direct that any recording, radio, television or broadcasting equipment is to be placed in a stationery location and handled in such a manner as possible so as not to disturb the proceedings or create a safety hazard.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-32. Notice of hearings

Notice of a hearing shall include but not be limited to the following:

(1) A statement of the time, place, and nature of the hearing;

(2) A statement of the legal authority and jurisdiction under which the hearing is to be held;

(3) A reference to the particular sections of the statutes and regulations involved;

(4) A short and plain statement of fact describing the nature of the hearing and the principal facts to be asserted therein, except that in the case of applications and petitions, the Commissioner may refer to or annex the application or petition.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-33. Appearance and representation

(a) **Taking appearances.** Parties shall enter their appearance at the beginning of the proceedings or at such time as may be designated by the Commissioner by giving their names and addresses and stating their positions or intentions in the proceedings.

(b) **Representation of parties.** (1) An individual who is a party to a proceeding may represent himself or herself. A bona fide officer designated by a partnership, corporation, association, or an employee of a governmental subdivision or agency that is a party to a proceeding, may represent that party's interest in the proceeding.

(2) A person may be represented in any proceeding by an attorney at law admitted to practice in this state. An attorney admitted to practice in the highest court of any other state may also be allowed to represent any person in a proceeding before the Commissioner in the discretion of the Commissioner and upon proper application to the Commissioner.

(3) An attorney or other authorized representative of a party shall file a Notice of Appearance with the Commissioner in the following form, except that a Notice of Appearance shall not be required of an attorney representing the insurance department in such proceedings:

STATE OF CONNECTICUT
INSURANCE DEPARTMENT

In the Matter of:

Docket No. _____

NOTICE OF APPEARANCE

Please enter my appearance in the above-designated matter on behalf of _____ .

I am authorized to accept service on behalf of said participant in this matter.

Signature

Name (Printed)

P.O. box/address

City, state and zip code

Telephone number (including area code)

After a notice of appearance has been filed in accordance with this section, copies of all pleadings, notices, rulings, or decisions shall be served on the person named in the notice of appearance.

(Effective September 25, 1992; amended February 1, 2001, August 5, 2009)

Sec. 38a-8-34. Consolidation of proceedings

Proceedings involving related questions of law or fact may be consolidated at the direction of the Commissioner.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-35. Ex parte communications

(a) Unless required for the disposition ex parte of matters authorized by law, neither the Commissioner nor any presiding officer shall communicate directly or indirectly with any person or party concerning any issue of fact or law involved in any contested case that has been commenced under these rules, except upon notice and opportunity for all parties to participate.

(b) Any hearing officer or presiding officer and the Commissioner may severally communicate with each other *ex parte* and may have the aid and advice of such members of the staff as are assigned to assist them in such contested case. This rule shall not be construed to preclude such necessary routine communications as are necessary to permit the staff to investigate facts and to audit the applicable records of any party in a contested case at any time before, during, and after the hearing thereof.

(c) Unless required for the disposition of *ex parte* matters authorized by law, no party or intervenor in a contested case, and no person who has a direct or indirect interest in the outcome of the case, shall communicate, directly or indirectly, in connection with any issue in that case, with the Commissioner, a hearing officer or with any employee or agent of the Insurance Department assigned to assist the hearing officer or Commissioner in such case, without notice and opportunity for all parties to participate in the communication.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-36. Continuance of hearing

On motion of the Commissioner, or presiding officer, or that of any party, the hearing may be adjourned or continued on such terms as the Commissioner or presiding officer may require.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-37. Amendment of notice of hearing

The Commissioner may amend any notice of hearing to incorporate additional matters or allegations and may continue or postpone the hearing for such reasonable time as justice requires to allow the parties to respond to such additional matters or allegations.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-38. Pre-hearing conference

(a) The Commissioner or presiding officer may, in his or her discretion, order counsel or any party to meet for a pre-hearing conference. Such conference may be held with one or more persons participating by telephone or other remote means.

(b) At a pre-hearing conference, the Commissioner or presiding officer may consider and take action with respect to any or all of the following: (1) simplification and clarification of the issues; (2) exchange of witnesses and exhibit list and copies of exhibits; (3) stipulations, admissions of fact, and stipulations concerning the contents, authenticity, or admissibility into evidence of documents; (4) matters of which official notice may be taken; (5) the schedule for exchanging pre-hearing motions or briefs, if any; (6) the method of service and filing of papers by the parties; (7) determination of hearing dates; (8) amendments to the complaint or answers thereto; (9) such other matters as may aid in the orderly and expeditious disposition of the proceeding.

(c) With respect to Insurance Department enforcement proceedings, an initial pre-hearing conference, unless determined by the presiding officer to be unnecessary or premature, shall be held within twenty-one days after filing of an answer. When a complaint names multiple respondents, the twenty-one day period shall commence from the later of (1) the date on which the last timely answer was filed, or (2) if one or more respondents have failed to answer, from the expiration of the latest period provided for filing an answer provided by section 38a-8-61 of the Regulations of Connecticut State Agencies.

(d) At or following the conclusion of any conference held pursuant to this section, the presiding officer or hearing officer shall enter a written ruling or order that recites any agreements reached and any procedural determinations made by the hearing officer.

(Effective September 25, 1992; amended February 1, 2001, August 5, 2009)

Sec. 38a-8-39. Rules of evidence

The following rules of evidences shall be applied at hearings:

(1) **General.** Any oral or documentary evidence may be received but the presiding officer shall, as a matter of policy, exclude irrelevant, immaterial or unduly repetitious evidence. The allegations and facts as stated in the Notice of Hearing or complaint issued in Insurance Department enforcement proceedings shall determine the relevance of evidence at the hearing. The Commissioner or presiding officer shall give effect to the rules of privilege recognized by law in Connecticut. Subject to these requirements and subject to the right of any party to cross-examine, any testimony may be received in written form.

(2) **Documentary evidence.** Documentary evidence may be received at the discretion of the Commissioner or presiding officer in the form of copies or excerpts, if the original is not readily available. Upon request by any party an opportunity shall be granted to compare the copy with the original which shall be subject to production by the person offering such copies, within the provisions of section 52-180 of the Connecticut General Statutes.

(3) **Cross examination.** Such cross examination may be conducted as the presiding officer shall find to be required for a full and true disclosure of the facts.

(4) **Facts noticed, department records.** The Commissioner or presiding officer, on his or her own initiative or at the request of any party, may take notice of judicially cognizable facts, including prior decisions and orders of the Commissioner or the department, and generally recognized technical or scientific facts within the Department's specialized knowledge.

(5) **Facts, noticed, procedure.** Parties shall be afforded an opportunity to contest the material so noticed by being notified before or during the hearing, or by an appropriate reference in preliminary reports or otherwise of the material noticed. The Commissioner shall nevertheless employ the department's experience, technical competence, and specialized knowledge in evaluating the evidence presented at the hearing for the purpose of making findings of the facts and arriving at a decision in any contested case.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-40. Filing of added exhibits and testimony

Upon order of the presiding officer before, during or after the hearing of a case, any party or intervenor shall prepare and file added exhibits and written testimony. Any party or intervenor filing added exhibits or testimony shall deliver copies of such to all other parties and intervenors, and shall file a certification regarding such delivery.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-41. Uncontested disposition of case

Unless precluded by law, any contested case may be resolved by stipulation, agreed settlement, consent order or default upon order of the Commissioner. Upon such disposition a copy of the order of the Commissioner shall be served on each

party in accordance with section 38a-8-18(d) of the Regulations of Connecticut State Agencies.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-42. The record in contested cases

The record in a contested case shall include:

- (1) All motions, applications, petitions, complaints, responsive pleadings, bills of particulars, notices of hearing, and intermediate rulings;
- (2) The evidence received and considered by the presiding officer;
- (3) Questions and offers of proof, objections, and the presiding officer's rulings thereon during the hearing;
- (4) The decision, opinion or report by the presiding officer or the Commissioner.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-43. Proposal for decision

(a) The Commissioner shall proceed in the following manner in contested cases where the Commissioner has not heard the case or read the record. The decision of the presiding officer shall not be adopted by the Commissioner until the presiding officer's proposal for decision is served upon all of the parties and until an opportunity has been afforded to each party and intervenor affected by the proposed decision to file exceptions, to present briefs, and to make oral argument before the Commissioner.

(b) The proposal for decision served upon the parties shall state the hearing officer's reasons therefor and each issue of law or fact necessary for the proposed decision.

(c) Compliance with this section may be waived by a written stipulation of the parties.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-44. Final decision

All final decisions and orders of the Commissioner concluding a contested case shall be in writing or orally stated and shall be made a part of the record of such case. The Commissioner shall serve a copy of the final decision on each party and intervenor in the manner required by the rules of practice and by chapter 54 of the Connecticut General Statutes. With the consent in writing of the respondent and notice to all others concerned, an order may be entered without holding of any hearing or the making of any findings of fact or conclusion of law.

(Effective September 25, 1992; amended February 1, 2001)

Secs. 38a-8-45—38a-8-46. Reserved

Part 2

**Special Provisions:
Hearings on Applications and Petitions**

Sec. 38a-8-47. General provisions

(a) The Commissioner shall hold a hearing on any application or petition where required by law and may in his or her discretion hold a hearing on any application or petition presented to the Commissioner where he or she deems a hearing to be necessary for a complete consideration of the matter.

(b) In addition to the general provisions of this article governing hearings, the following special provisions, sections 38a-8-48 to 38a-8-53, inclusive, of the Regula-

tions of Connecticut State Agencies shall apply to all hearings on applications and petitions filed with the Commissioner.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-48. Party and intervenor status

(a) In issuing the notice of hearing, the Commissioner shall designate as parties those persons known to the Commissioner whose legal rights, duties or privileges are being determined. All other persons proposing to be named or admitted as parties or intervenors shall apply for such designation in the manner hereinafter described. No other person shall be or have standing before the Commissioner as a party or intervenor.

(b) The Commissioner or presiding officer shall grant a person status as a party in a contested case if the Commissioner or presiding officer finds that:

(1) such person has submitted a written petition to the the Insurance Department and mailed copies to all parties, at least five days before the date of hearing; and

(2) the petition states facts that demonstrate that the petitioner's legal rights, duties or privileges shall be specifically affected by the Commissioner's decision in the contested case.

(c) the Commissioner or presiding officer may grant a person status as an intervenor in a contested case if the Commissioner or presiding officer finds that:

(1) such person has submitted a written petition to the Insurance Department and mailed copies to all parties, at least five days before the date of hearing; and

(2) the petition states facts that demonstrate that the petitioner's participation is in the interests of justice and will not impair the orderly conduct of the proceedings.

(d) The five-day requirement in subsections (a) and (b) of this section may be waived at any time by the Commissioner or presiding officer on a showing of good cause.

(e) If a petition is granted pursuant to subsection (c) of this section, the Commissioner or presiding officer may limit the intervenor's participation to designated issues in which the intervenor has a particular interest as demonstrated by the petition and shall define the intervenor's rights to inspect and copy records, physical evidence, papers and documents, to introduce evidence, and to argue and cross-examine on those issues. The Commissioner or presiding officer may further restrict the participation of an intervenor in the proceedings, including the rights to inspect and copy records, to introduce evidence and to cross-examine, so as to promote the orderly conduct of the proceedings.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-49. Petition to be designated a party or intervenor

The petition to be designated a party or intervenor as required by section 38a-8-48 of the Regulations of Connecticut State Agencies shall include the following:

(1) the petitioner's name and address;

(2) a legal description of the petitioner;

(3) the identity of the individual on whom papers are to be served during the course of the contested case;

(4) for petitions to be designated a party, a description of the facts that demonstrate that the petitioner's legal rights, duties or privileges shall be specifically affected by the Department's decision in the contested case; and

(5) for petitions to be designated an intervenor, a description of the facts that demonstrate that the petitioner's participation is in the interests of justice and will not impair the orderly conduct of the proceedings.

(Effective September 25, 1992; amended February 1, 2001, February 1, 2011)

Sec. 38a-8-50.

Repealed, February 1, 2001

Sec. 38a-8-51. Procedure concerning added parties

(a) **Notice of designation.** In the event that the Commissioner grants any petitioner status as a party or intervenor after service of the initial notice of hearing in a contested case, the Commissioner or presiding officer shall give notice thereof to all parties theretofore designated or admitted. The form of the notice shall be a copy of the order of the department naming or admitting such added party and a copy of any petition filed by such added party requesting designation as a party. Service of such notice shall be in the manner provided in these rules.

(b) **Public comment.** In any hearing on a petition, the Commissioner or the presiding officer may allow interested persons who do not wish to be made parties to present comments either orally or in writing. Such comments shall be made available to all parties and petitioners, and shall be given the same weight as legal argument. The presiding officer may require any such statement to be given under oath or affirmation.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-52. Hearing procedure

(a) **Order of presentation.** In hearings on petitions, the party that shall open and close the presentation of any part of the matter shall be the petitioner. In a case where the direct testimony has already been submitted in written form as provided by the rules of practice, the hearing shall open with the direct testimony being read for the benefit of those present or, at the discretion of the Commissioner or presiding officer, the hearing shall open with the cross-examination of persons who have given written testimony. In the event any person has given written testimony and is not available for such cross-examination at the time and place directed by the Commissioner or presiding officer, all of such written testimony may be discarded and removed from the record at the discretion of the Commissioner or presiding officer.

(b) **Limiting number of witnesses.** To avoid unnecessary cumulative evidence, the Commissioner or the presiding officer may limit the number of witnesses or the time for the testimony upon a particular issue in the course of any hearing pertaining to a petition for party or intervenor status.

(c) **Limitation of direct case.** The direct case of any petitioner shall consist substantially of the written statement of the petition, and the exhibits and other materials annexed thereto unless the Commissioner or presiding officer shall rule otherwise for good cause shown. All prepared written testimony filed with the petition shall be received in evidence with the same force and effect as though it were stated orally by the witnesses, provided that each such witness shall be present at the hearing at which such prepared written testimony is offered, shall adopt such written testimony under oath, and shall be made available for cross-examination as directed by the Commissioner or presiding officer. Prior to its admission, such written testimony shall be subject to objections by any party. The Department, any party or intervenor may waive the attendance of such witness at the hearing. Where the attendance at the hearing of all witnesses is waived by all parties, intervenors and the Department, the matters at issue in the hearing may be decided solely on the basis of the prepared written testimony.

(d) The Commissioner or presiding officer may by order, require any party or other participant that proposes to offer substantive, technical or expert testimony,

to prefile such testimony in written form on such date before or during the public hearing as the Commissioner or presiding officer shall direct. Such prefiled written testimony shall be received in evidence with the same force and effect as though it were stated orally by the witnesses who have given the evidence, provided that each witness shall be present at the hearing at which the prefiled written testimony is offered, shall adopt the written testimony under oath, and shall be made available for cross-examination as directed by the Commissioner or presiding officer. Prior to its admission, such written testimony shall be subject to objections by any party.

(e) The Commissioner or presiding officer may allow oral testimony or arguments to be presented by telephone or other electronic means, provided the testimony or arguments are amplified so that the public attending such hearing may hear such testimony or arguments.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-53. Reserved

Part 3

**Special Provisions:
Hearings in Enforcement Proceedings**

Sec. 38a-8-54. General

In addition to the general provisions of this article governing hearings, the following special provisions shall apply to all proceedings instituted by the Commissioner for the revocation or suspension of any license, in any proceeding where a fine may be imposed, and in any proceeding under sections 38a-815 to 38a-819, inclusive, of the Connecticut General Statutes alleging unfair practices.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-55. Hearings — licenses, fines

Except as provided in section 38a-8-56 of the Regulations of Connecticut State Agencies or any provision of the Connecticut General Statutes, no license may be revoked or suspended nor any fine imposed for violation of any provision within title 38a of the Connecticut General Statutes or the Regulations of Connecticut State Agencies without prior notice and an opportunity to be heard.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-56. Suspension pending proceedings

If the Commissioner finds that the public health, safety or welfare imperatively requires emergency action, and incorporates a finding to that effect in his or her order, summary suspension of a license may be ordered pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined by the Commissioner.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-57. Hearings — unfair practices

Proceedings instituted by the Commissioner alleging unfair practices under sections 38a-815 to 38a-819, inclusive, of the Connecticut General Statutes and Regulations promulgated thereunder shall be conducted in accordance with the provisions of said sections as supplemented by the rules of practice.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-58. Intervention — unfair practices proceeding

The Commissioner shall permit any person to intervene in any proceeding under sections 38a-817 and 38a-818 of the Connecticut General Statutes in accordance with section 38a-8-49 of the Regulations of Connecticut State Agencies.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-59. Notice — time

Unless a greater or lesser time is required by statute or regulation with regard to any proceeding subject to this section, notice shall be given to the respondent at least thirty (30) days prior to a hearing.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-60. Complaint

(a) **Complaint issuance.** All enforcement proceedings instituted by the Commissioner for the revocation or suspension of any license or imposition of a fine, or both, shall be initiated by serving on each respondent a complaint which shall specify in reasonable detail the conduct alleged to constitute a violation of any regulation or statutory provision which the commissioner has jurisdiction to enforce and contain the information required by section 38a-8-32 of the Regulations of Connecticut State Agencies and section 4-177 of the Connecticut General Statutes. In addition, the complaint shall include a notice that the respondent's failure to file an answer in accordance with section 38a-8-61 of the Regulations of Connecticut State Agencies shall allow the commissioner or the presiding officer to treat as admitted the allegations in the complaint and issue a decision by default against the respondent, pursuant to section 38a-8-62 of the Regulations of Connecticut State Agencies.

(b) **Amendments to complaint.** The Insurance Department may file and serve, not later than the day on which a hearing is scheduled, an amended complaint that includes new matters of fact or law once as a matter of course before the respondent answers the complaint. After the filing of a respondent's answer to the complaint, upon motion by the department, the presiding officer may permit the Insurance Department to amend the complaint to include new matters of fact or law, after considering whether the Insurance Department has shown good cause for the amendment and whether any respondent will suffer any unfair prejudice if the amendment is allowed.

(Effective September 25, 1992; amended February 1, 2001, August 5, 2009)

Sec. 38a-8-61. Answer

(a) **Form, content, affirmative defenses.** The respondent in any enforcement proceeding shall file an answer to the complaint with the Commissioner no later than twenty (20) days after service of the complaint. An answer shall specifically admit, deny, or state that the respondent does not have and is unable to obtain sufficient information to admit or deny each allegation in the complaint. When a respondent intends to deny only part of an allegation, the respondent shall specify so much of it as is admitted and deny only the remainder. A statement of a lack of information shall be deemed a denial. Any allegation not denied in whole or in part shall be deemed admitted. Any affirmative defense shall be asserted specifically in the answer.

(b) **Amendments to answer.** Upon motion by a respondent, the presiding officer may, after considering good cause shown by the respondent and any unfair prejudice which may result to any other party, permit an answer to be amended up to and including the date scheduled for the hearing.

(c) **Extension of time to answer amended complaint.** If a complaint is amended pursuant to section 38a-8-60(b) of the Regulations of Connecticut State Agencies, the time for filing an answer or amended answer shall be the greater of the original time period within which the respondent is required to respond, or fourteen days after service of the amended complaint. If any respondent has already filed an

answer, such respondent shall have fourteen days after service of the amended complaint to file an amended answer, unless otherwise ordered by the presiding officer.

(d) **Failure to answer, default.** A respondent's failure to file an answer with the insurance department within the time required by this section shall allow the commissioner or the presiding officer, in the exercise of his or her discretion, pursuant to section 38a-8-62 of the Regulations of Connecticut State Agencies to: (1) treat as admitted by the respondent the allegations in the complaint; and (2) issue a default decision against the respondent as provided by section 38a-8-62 of the Regulations of Connecticut State Agencies.

(Effective September 25, 1992; amended February 1, 2001, August 5, 2009)

Sec. 38a-8-62. Default decisions

The Commissioner or presiding officer may issue a default decision against a respondent that fails to answer the complaint within the time afforded under section 38a-8-61 of the Regulations of Connecticut State Agencies, or a party that fails to appear at a pre-hearing conference held pursuant to section 38a-8-38 of the Regulations of Connecticut State Agencies of which the party has due notice, or a party that fails to appear at any duly noticed hearing. If the defaulting party is the respondent, the Commissioner or presiding officer may deem the allegations against the respondent admitted. If the defaulting party is the insurance department, the Commissioner or presiding officer may issue a default decision ordering that the complaint be dismissed.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-63. Reopened hearing

A respondent may, for good cause shown, file a motion to set aside a decision rendered by default no later than sixty (60) days of the entry thereof. If a default was entered for failure of the respondent to file an answer, the respondent shall submit said answer with the motion to reopen. Upon a showing of good cause, the Commissioner may grant said motion and shall schedule the hearing at the earliest date convenient to the Commissioner.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-64. Conduct of enforcement hearing

(a) Unless modified by the Commissioner or the presiding officer, the order of proof in enforcement proceedings shall be as follows:

- (1) evidence of the violations alleged;
- (2) cross-examination of the department's witnesses;
- (3) evidence by respondent and his witnesses;
- (4) cross-examination of respondent and his witnesses;
- (5) such rebuttal or other evidence on behalf of the department or other party in interest as may be allowed by the Commissioner.

(b) At the discretion of the Commissioner or presiding officer, the parties may be ordered to file proposed findings of facts and conclusions of law, or post-hearing briefs, or both. The Commissioner or presiding officer may order that such proposed findings and conclusions be filed together with, or as part of, post-hearing briefs.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-65. Jurisdictional objections

After proceedings have commenced in a contested case, objections to the jurisdiction of the Insurance Department may be made to the Commissioner at any time prior to the final decision.

(Effective September 25, 1992; amended February 1, 2001, August 5, 2009)

Sec. 38a-8-66. Reserved

ARTICLE V

APPEALS TO COMMISSIONER

Sec. 38a-8-67. Appeals under Sections 38a-329 and 38a-328-14

(a) **General.** This section and section 38a-8-68 of the Regulations of Connecticut State Agencies set forth the procedure to be followed in the disposition of appeals to the Commissioner pursuant to section 38a-329 of the Connecticut General Statutes and section 38a-328-14 of the Regulations of Connecticut State Agencies.

(b) **Time limit for appeal.** Appeals to the Commissioner under this section shall be made no later than thirty (30) days after the date notice was mailed of the final action, decision or ruling of the Connecticut Automobile Insurance Assigned Risk Plan, the Connecticut Insurance Placement Facility (Fair Plan), the Connecticut Worker's Compensation Insurance Plan or other residual market mechanism authorized under section 38a-329 of the Connecticut General Statutes to provide insurance coverage for applicants who are in good faith entitled to but are unable to procure the insurance through ordinary methods. Appeals to the Commissioner under this section that are filed beyond the appeal period as established by this section, will be accepted only in the discretion of the Commissioner.

(c) **Form of appeal.** All appeals to the Commissioner shall be in writing and conform to the general provisions of the Regulations of Connecticut State Agencies where applicable and, in addition, shall set forth clearly and concisely the basis for disputing the action, decision or ruling, together with all pertinent documents or exhibits attached thereto.

(d) **Scope of appeal.** Appeals made to the Commissioner under this section shall be limited to a review for compliance with applicable statutes, regulations, and the forms, procedure, rates, rating plans and rules of the Connecticut Automobile Insurance Assigned Risk Plan, the Connecticut Insurance Placement Facility (Fair Plan), the Connecticut Worker's Compensation Insurance Plan or other residual market mechanism established pursuant to Section 38a-329 of the Connecticut General Statutes.

(e) **Decision, hearing.** No later than thirty (30) days after receipt of the written appeal, the Commissioner shall review the matter in accordance with subsection (d) of this section, and affirm or reverse the decision or ruling from which appeal to the Commissioner was taken. When the Commissioner deems it necessary to decide the matter, the Commissioner in his or her discretion may solicit additional information from the appellant or the manager or committee designated to operate the particular plan or residual market mechanism, and in his or her discretion hold a hearing to hear and receive testimony.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-68. Reserved

ARTICLE VI

INFORMAL COMPLAINTS ALLEGING VIOLATIONS OF THE INSURANCE LAWS OR REGULATIONS

Sec. 38a-8-69. Form

The Commissioner will accept informal complaints alleging violations of title 38a of the Connecticut General Statutes or the regulations promulgated thereunder from any person. Although no form of informal complaint is required, it is requested that such complaints clearly state the name, address, and telephone number of the complainant; the name, address, and telephone number of the person complained of; a brief description of the facts relied upon; and, if the complaint concerns a rate, policy form or document of any kind, that it be identified or a copy attached to the complaint. It is also requested that any person filing a complaint indicate whether they will be available to testify with regard to such complaint if formal proceedings thereon are instituted by the Commissioner.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-70. Disposition of informal complaints

Where the Commissioner, in his or her discretion, determines that an informal complaint alleges a violation of title 38a of the Connecticut General Statutes or regulations promulgated thereunder, and where the Commissioner determines that the complaint appears to be susceptible to informal adjustment, a copy or a statement of the substance thereof will be transmitted to each person complained of in an endeavor to have it satisfied by correspondence and thus obviate the need for formal proceedings.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-71. Reserved

ARTICLE VII

REGULATIONS

Sec. 38a-8-72. Notice of intent to adopt regulations

Prior to the adoption of any regulation, the Commissioner shall give such notice as is required by section 4-168 of the Connecticut General Statutes or other applicable statutes.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-73. Request for advance notice of regulation adoption proceedings

(a) **Filing and form.** Any person or group may file a request with the Commissioner for advance notice of regulation adoption proceedings. The request shall be clearly titled "Request for Advance Notice of Regulation Adoption Proceedings" and shall state in order:

- (1) the name of the person or group making the request,
- (2) the address of the person or group to which responses should be mailed; and
- (3) the date of the request.

(b) **Time and form of notice.** The Commissioner shall give at least thirty (30) days' notice of the adoption of a regulation. The notice shall include:

(1) either a statement of the terms or of the substance of the proposed regulation or description sufficiently detailed so as to apprise persons likely to be affected of the issues and subjects involved in such proposed regulation;

(2) a statement of the purposes for which the regulation is proposed;

(3) a reference to the statutory authority for such proposed regulation; and

(4) the time when, the place where, and the manner in which interested persons may present their views thereon, and such additional information as may be required by law.

(c) **Effective period.** The request for advance notice of regulation adoption proceeding shall be in effect only for the calendar year in which it was filed and all requests shall expire on December 31 each year.

(d) **Fees.** The fee for providing advance notice of regulation adoption proceedings shall be \$20.00 per year and each request shall be accompanied by a check or money order payable to the Treasurer, State of Connecticut.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-74. Submission of data, views, and argument

All interested persons may submit data, views, and arguments in writing to the Commissioner not more than thirty (30) days after notice of intent to adopt the regulation has been published. Oral presentations may be allowed by the Commissioner in his or her discretion, but an opportunity to present oral argument shall be granted if requested by fifteen (15) persons, by a governmental subdivision or agency, or by an association having not less than fifteen (15) members, provided notice of such request is made to the Commissioner no later than fourteen (14) days after the date of publication of the notice of intent to adopt regulations in the Connecticut Law Journal. The Commissioner, in his or her discretion, may require that the oral argument be recorded or transcribed at the expense of the persons making oral argument or that a written summary be provided which shall be open to inspection by the public.

(Effective September 25, 1992; amended February 1, 2001)

Sec. 38a-8-75. Availability of regulations

All the regulations and currently pending proposed regulations of the Commissioner shall be available for inspection during normal business hours at the Commissioner's principal office. Copies of all such regulations shall be available to any person on request. The Commissioner may charge a reasonable fee for each copy in accordance with the Freedom of Information Act, chapter 14 of the Connecticut General Statutes.

(Effective September 25, 1992; amended February 1, 2001)

Personal Data

Sec. 38a-8-76. Personal data

(a) Definitions

(1) The following definitions shall apply to these regulations:

(A) "Category of personal Data" means the classification of personal information set forth in the Personal Data Act, Conn. Gen. Stat. 4-190 (9).

(B) "Other Data" means any information which because of name, identification number, mark or description can be readily associated with a particular person.

(C) "Licensee" means individuals licensed by the Insurance Commissioner as insurance agents, insurance brokers, public adjusters, temporary agents, casualty claim adjusters, excess line brokers, fraternal agents, motor vehicle physical damage appraisers, and certified insurance consultants.

(2) Terms defined in Conn. Gen. Stat. Sec. 4-190 shall apply to these regulations.

(b) General Nature and Purpose of Personal Data

(1) The Insurance Department maintains the following personal data system:

(A) Personnel Records.

(i) All personnel records are maintained at the Insurance Department, Room 429, State Office Building, Hartford, Connecticut.

(ii) Personnel records are maintained in both automated and manual form.

(iii) Personnel records are maintained for the purpose of retaining payroll, health discipline and related personnel information concerning Insurance Department employees.

(iv) Personnel records are the responsibility of the Business Manager of the Insurance Department, Room 429, State Office Building, Hartford, Connecticut. All requests for disclosure or amendment of these records should be directed to the Business Manager.

(v) Routine sources for information retained in personnel records include the employee, previous employers of the employee, references provided by the applicants, the employee's supervisor, the Comptroller's Office, Department of Administrative Services, Division of Personnel and Labor Relations, and State insurance carriers.

(vi) Personal data in personnel records are collected, maintained and used under authority of the State Personnel Act, Conn. Gen. Stat. Sec. 5-193 et seq.

(B) License Records.

(i) License records for licensees are maintained in the Licensing and Investigations Division of the Insurance Department, Room 449, State Office Building, Hartford, Connecticut.

(ii) License records are maintained in both automated and manual form.

(iii) License records are maintained for the purpose of determining the qualifications of applicants and the continued suitability of licensees.

(iv) Licensee records are maintained with the Director of the Licensing and Investigations Division of the Insurance Department, Room 449, State Office Building, Hartford, Connecticut. All requests for disclosure or amendment of these records should be directed to the Director.

(v) Routine sources of information retained in license records include license application, financial, employment, criminal history and other personal background data and information secured and maintained by the Insurance Department for individuals licensed by the Department.

(c) Categories of Personal Data.**(1) Personnel Records**

(A) The following categories of personal data may be maintained in personnel records:

(i) Educational records.

(ii) Medical or emotional condition or history.

(iii) Employment or business history.

(iv) Other reference records.

(B) The following categories of other data may be maintained in personnel records:

(i) Addresses.

(ii) Marital status.

(iii) Telephone numbers.

(c) Personnel records are maintained on employees of the Insurance Department and applicants for employment with the Insurance Department.

(2) Licensee Records

(A) The following categories of personal data may be maintained in license records of licensees.

- (i) Educational records.
- (ii) Medical or emotional condition or history.
- (iii) Employment or business history.
- (iv) Criminal records.
- (v) Police investigation records.
- (vi) Investigative records from other jurisdictions.
- (vii) Other reference records.

(B) The following categories of other data may be maintained in license records:

- (i) Application records.
- (ii) Renewal records.
- (iii) Removal records.
- (iv) Records of administrative action.
- (v) Addresses.
- (vi) Marital status.
- (vii) Social security number.
- (viii) Telephone numbers.

(C) License records are maintained on applicants for and holders of licenses to act as an insurance agent, an insurance broker, a public adjuster, a temporary agent, a casualty claim adjuster, an excess line broker, a fraternal agent, a motor vehicle physical damage appraiser, and a certified insurance consultant.

(d) **Maintenance of Personal Data**

(1) Personal data will not be maintained unless relevant and necessary to accomplish the lawful purposes of the Insurance Department. Where the Insurance Department finds irrelevant or unnecessary public records in its possession, the Department shall dispose of the records in accordance with its records retention schedule and with the approval of the Public Records Administrator as per Conn. Gen. Stat. Sec. 11-8a, or if the records are not disposable under the records retention schedule, request permission from the Public Records Administrator to dispose of the records under Conn. Gen. Stat. Sec. 11-8a.

(2) The Insurance Department will collect and maintain all records with accuracy and completeness.

(3) Insofar as it is consistent with the needs and mission of the Insurance Department, the Department wherever practical, shall collect personal data directly from the persons to whom a record pertains.

(4) Insurance Department employees involved in the operation of the Agency's personal data systems will be informed of the provisions of the (A) Personal Data Act, (B) the Department's regulations adopted pursuant to Sec. 4-196, (C) the Freedom of Information Act and (D) any other state or federal statute or regulations concerning maintenance or disclosure or personal data kept by the Department.

(5) All Insurance Department employees shall take reasonable precautions to protect personal data under their custody from the danger of fire, theft, flood, natural disaster and other physical threats.

(6) The Insurance Department shall incorporate by reference the provisions of the Personal Data Act and regulations promulgated thereunder in all contracts, agreements or licenses for the operation of a personal data system or for research, evaluation and reporting of personal data for the Department or on its behalf.

(7) An agency requesting personal data from any other state agency shall have an independent obligation to insure that the personal data is properly maintained.

(8) Only Insurance Department employees who have a specific need to review personal data records for lawful purposes of the Department shall be entitled to access to such records under the Personal Data Act.

(9) The Insurance Department will keep a written up-to-date list of individuals entitled to access to each of the agency's personal data systems.

(10) The Insurance Department will insure against unnecessary duplication of personal data records. In the event it is necessary to send personal data records through interdepartmental mail, such records will be sent in envelopes or boxes sealed and marked "confidential."

(11) The Insurance Department will insure that all records in manual personal data systems are kept under lock and key and, to the greatest extent practical, are kept in controlled access areas.

(12) With respect to the automated personal data system:

(A) The Insurance Department shall, to the greatest extent practical, locate automated equipment and records in a limited access area.

(B) To the greatest extent practical, the Insurance Department shall require visitors to such area to sign a visitor's log and permit access to said area on a bona-fide need-to-enter basis only.

(C) The Insurance Department, to the greatest extent practical, will insure that the regular access to automated equipment is limited to operations personnel.

(D) The Insurance Department shall utilize appropriate access control mechanisms to prevent disclosure of personal data to unauthorized individuals.

(e) **Disclosure of Personal Data**

(1) Within four business days of receipt of a written request therefor, the Insurance Department shall mail or deliver to the requesting individual a written response in plain language, informing him/her as to whether or not the Department maintains personal data on that individual, the category and location of the personal data maintained on that individual and procedures available to review the records.

(2) Except where nondisclosure is required or specifically permitted by law, the Insurance Department shall disclose to any person upon written request all personal data concerning that individual which is maintained by the agency. The procedures for disclosure shall be in accordance with Conn. Gen. Stat. Secs. 1-15 through 1-21k. If the personal data is maintained in coded form, the Department shall transcribe the data into a commonly understandable form before disclosure.

(3) The Insurance Department is responsible for verifying the identity of any person requesting access to his/her own personal data.

(4) The Insurance Department is responsible for ensuring that disclosure made pursuant to the Personal Data Act is conducted so as not to disclose any personal data concerning persons other than the person requesting the information.

(5) The Insurance Department may refuse to disclose to a person medical, psychiatric or psychological data on that person if the agency determines that such disclosure would be detrimental to that person.

(6) In any case where the Insurance Department refuses disclosure, it shall advise that person of his/her right to seek judicial relief pursuant to the Personal Data Act.

(7) If the Insurance Department refuses to disclose medical, psychiatric or psychological data to a person based on its determination that disclosure would be detrimental to that person and non-disclosure is not mandated by law, the Department shall, at the written request of such person, permit a qualified medical doctor to review

the personal data contained in the person's record to determine if the personal data should be disclosed. If disclosure is recommended by the person's medical doctor, the agency shall disclose the personal data to such person; if nondisclosure is recommended by such person's medical doctor, the Department shall not disclose the personal data and shall inform such person of the judicial relief provided under the Personal Data Act.

(8) The Insurance Department shall maintain a complete log of each person, individual, agency or organization who has obtained access or to whom disclosure has been made of personal data under the Personal Data Act, together with the reason for each such disclosure or access. This log must be maintained for not less than five years from the date of such disclosure or access or for the life of the personal data record, whichever is longer.

(f) Contesting the Content of Personal Data Records

(1) Any person who believes that the Insurance Department is maintaining inaccurate, incomplete or irrelevant personal data concerning him/her may file a written request with the Department for correction of said personal data.

(2) With 30 days of receipt of such request, the Insurance Department shall give written notice to that person that it will make the requested correction, or if the correction is not to be made as submitted, the Department shall state the reason for its denial of such request and notify the person of his/her right to add his/her own statement to his/her personal data records.

(3) Following such denial by the Insurance Department, the person requesting such correction shall be permitted to add a statement to his or her personal data records setting forth what that person believes to be an accurate, complete and relevant version of the personal data in question. Such statements shall become a permanent part of the Department's personal data system and shall be disclosed to any individual, agency or organization to which the disputed data is disclosed.

(g) Uses To Be Made of the Personal Data

(1) Personnel Records

(A) Personnel records are routinely used for evaluating the qualifications of employment applicants and the work performance of employees of the Insurance Department. Users include the Business Manager and other state officers and employees with responsibility for evaluating the work performance of employees of the Department, and others where permitted or required by law.

(B) The Insurance Department retains personnel records according to guidelines published by the Public Records Administrator, Connecticut State Library.

(2) License Records

(A) License records of individuals are routinely used for evaluating the suitability of applicants and the continued suitability of licensees. Users include all officers and employees of the Department, police authorities and others where permitted or required by law.

(B) The Insurance Department retains licensee records according to guidelines published by the Public Records Administrator, Connecticut State Library.

(3) When an individual is asked to supply personal data to the Insurance Department the Department shall disclose to that individual, upon request:

(A) The name of the Department and division within the Department requesting the personal data;

(B) The legal authority under which the Insurance Department is empowered to collect and maintain the personal data;

(C) The individual's rights pertaining to such records under the Personal Data Act and agency regulations;

(D) The known consequences arising from supplying or refusing to supply the requested personal data;

(E) The proposed use to be made of the requested personal data.

(Effective September 25, 1992)

Secs. 38a-8-77—38a-8-100. Reserved

Standards on Hazardous Financial Condition

Sec. 38a-8-101. Authority

Sections 38a-8-101 to 38a-8-104, inclusive, are adopted pursuant to the authority of Section 38a-8 of the General Statutes as necessary to implement Sections 38a-71, 38a-72, 38a-256, 38a-620, and 38a-911 of the General Statutes.

(Effective September 25, 1992)

Sec. 38a-8-102. Purpose

The purpose of this regulation is to set forth the standards which the Insurance Commissioner may use for identifying 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.

Sections 38a-8-101 to 38a-8-104, inclusive, shall not be interpreted to limit the powers granted the Commissioner by any laws or parts of laws of this state, nor shall this regulation be interpreted to supercede any laws or parts of laws of this state.

(Effective September 25, 1992)

Sec. 38a-8-103. Standards

The following standards, either singly or a combination of two or more, may be considered by the Commissioner to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to its policyholders, creditors or the general public. The Commissioner may consider:

(1) adverse findings reported in financial condition and market conduct examination reports, audit reports, and actuarial opinions, reports or summaries;

(2) the National Association of Insurance Commissioners Insurance Regulatory Information System and its other financial analysis solvency tools and reports;

(3) whether the insurer has made 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 insurer, when considered in light of the assets held by the insurer 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 insurer's policies and contracts;

(4) the ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the insurer'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;

(5) whether the insurer's operating loss in the last twelve month period or any shorter period of time, including but not limited to net capital gain or loss, change in non-admitted assets, and 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;

(6) whether the insurer's operating loss in the last twelve-month period or any shorter period of time, excluding net capital gains, is greater than twenty percent (20%) of the insurer's remaining surplus as regards policyholders in excess of the minimum required;

(7) whether a reinsurer, obligor or any entity within the insurer's insurance holding company system, is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligations, and which in the opinion of the Commissioner may affect the solvency of the insurer;

(8) contingent liabilities, pledges or guaranties which either individually or collectively involve a total amount which in the opinion of the Commissioner may affect the solvency of the insurer;

(9) whether any person controlling a substantial portion of the net written premiums of an insurer is delinquent in the transmitting to, or payment of, net premiums to the 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 the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the Commissioner;

(14) whether management of an insurer either has filed any false or misleading sworn financial statement, or has released false or misleading financial statement to lending institutions or to the general public, or 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 insurer has experienced or will experience in the foreseeable future cash flow or liquidity problems;

(17) whether management has established reserves that do not comply with minimum standards established by state insurance laws, regulations, statutory accounting standards, sound actuarial principles or standards of practice;

(18) whether management persistently engages in material under-reserving that results in adverse reserve development to meet its claims;

(19) whether transactions among affiliates, subsidiaries or any other person who directly or indirectly controls the operation of the insurer, for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity or diversity to assure the insurer's ability to meet its outstanding obligations as they mature;

(20) any other finding determined by the Commissioner to be hazardous to the insurer's policyholders, creditors or general public.

(Effective September 25, 1992; amended December 8, 2010)

Sec. 38a-8-104. Commissioner's authority

(a) For the purposes of making a determination of an insurer's financial condition under this regulation, the Commissioner may:

(1) disregard any credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired or otherwise subject to a delinquency proceeding;

(2) make appropriate adjustments including disallowance to asset values attributable to investments in or transactions with parents, subsidiaries or affiliates, consistent with the National Association of Insurance Commissioners Accounting Policies and Procedures Manual, state laws or regulations;

(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;

(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 12-month period.

(b) If the Commissioner determines that the continued operation of the insurer licensed to transact business in this state may be hazardous to its policyholders, creditors or the general public, then the commissioner may, upon such determination, issue an order requiring the insurer to:

(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 dividend by an insurer to its stockholders or to its policyholders;

(6) file reports in a form acceptable to the Commissioner 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 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;

(10) correct corporate governance practice deficiencies, and adopt and utilize governance practices acceptable to the Commissioner;

(11) provide a business plan to the Commissioner in order to continue to transact business in the state;

(12) adjust rates for any non-life insurance product written by the insurer that the Commissioner considers necessary to improve the financial condition of the insurer.

If the insurer is a foreign insurer the Commissioner's order may be limited to the extent provided by statute.

(c) An insurer subject to an order under Subsection (b) may request a hearing to review that order. The notice of hearing shall be served upon the insurer pursuant to the Rules of Practice of the Insurance Department. The notice of hearing shall state the time and place of hearing, and the conduct, condition or ground upon which the Commissioner based the order. Unless mutually agreed between the Commissioner and the insurer, the hearing shall occur not less than ten (10) days nor more than thirty (30) days after notice is served. The Commissioner shall hold all hearings under this subsection privately, unless the insurer requests a public hearing, in which case the hearing shall be public.

(Effective September 25, 1992; amended December 8, 2010)

Privacy of Consumer Financial Information

Sec. 38a-8-105. Scope

Sections 38a-8-105 to 38a-8-123 of the Regulations of Connecticut State Agencies govern the treatment of nonpublic personal financial information about individuals by all licensees of the Connecticut Insurance Department and are applicable to nonpublic personal financial information about individuals who obtain or are beneficiaries of products or services primarily for personal, family, or household purposes from licensees. Sections 38a-8-105 to 38a-8-123 of the Regulations of Connecticut State Agencies shall not apply to information about companies or about individuals who obtain products or services for business, commercial, or agricultural purposes, but are applicable to nonpublic personal financial information about individuals who obtain products or services for personal, family, or household purposes from licensees.

(Adopted effective June 7, 2002)

Sec. 38a-8-106. Definitions

As used in sections 38a-8-105 to 38a-8-123, inclusive, of the Regulations of Connecticut State Agencies:

(1) “Affiliate” means any company that controls, is controlled by or is under common control with another company;

(2) “Affinity program” is a relationship between a financial institution and an unaffiliated third party in which the unaffiliated third party facilitates the financial institution’s efforts to market the financial institution’s products or services to the unaffiliated third party’s customers or members or endorses such financial institution’s products or services;

(3) “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;

(4) “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;

(5) “Commissioner” means the Insurance Commissioner of the State of Connecticut;

(6) “Company” means any corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship, or similar organization;

(7) “Consumer” means an individual or that individual’s legal representative, 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 financial information.

(A) “Consumer” includes, but is not limited to:

(i) An individual who provides nonpublic personal financial 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 regardless of whether the licensee establishes an ongoing advisory relationship; or

(ii) An applicant for insurance prior to the inception of insurance coverage.

(B) 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 for, or other services to, that financial institution;

(C) An individual is a licensee's consumer if the licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party other than as permitted under section 38a-8-116, 38a-8-117, or 38a-8-118 of the Regulations of Connecticut State Agencies and the individual is either:

- (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.

(D) If the licensee provides the initial, annual, and revised notices as set forth in sections 38a-8-107, 38a-8-108, and 38a-8-111 of the Regulations of Connecticut State Agencies to the plan sponsor, group insurance or annuity contract holder, or policyholder of a workers' compensation plan, and further, if that licensee does not disclose to a nonaffiliated third party nonpublic personal financial information about such an individual other than as permitted under section 38a-8-116, 38a-8-117, or 38a-8-118 of the Regulations of Connecticut State Agencies, an individual is not the consumer of such 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;

- (ii) covered under a group insurance or annuity contract issued by the licensee; or
- (iii) a claimant covered by a workers' compensation plan.

(E) An individual is not a consumer solely because he or she is a beneficiary of a trust for which the licensee is a trustee; and

(F) An individual is not a consumer solely because he or she has designated the licensee as trustee for a trust;

(8) "Consumer reporting agency" means "consumer reporting agency" as defined in section 603(f) of the federal Fair Credit Reporting Act (15 USC 1681a(f));

(9) "Control" means:

(A) Ownership, ability, 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 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; or

(C) The power to exercise (directly or indirectly) a controlling influence over the management or policies of the company, as the commissioner determines;

(10) "Customer" means a consumer who has a customer relationship with a licensee;

(11) "Customer relationship" means a continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family, or household purposes.

(A) A consumer has a continuing relationship with a licensee if, for example:

(i) The consumer is a current policyholder of an insurance product issued by or through the licensee; or

(ii) The consumer 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 if, for example:

(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 a claimant under a policy and has submitted a claim under that policy choosing a settlement option involving an ongoing relationship with the licensee;

(v) The customer's policy is lapsed, expired, paid up, 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 regulation, communication at the direction of a state or federal authority, or promotional materials;

(vi) 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; or

(vii) 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;

(12) "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 federal Bank Holding Company Act of 1956 (12 USC 1843(k)). "Financial institution" shall not include:

(A) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the federal Commodity Futures Trading Commission under the federal Commodity Exchange Act (7 USC 1 et seq.);

(B) The Federal Agricultural Mortgage Corporation or any entity charged and operating under the federal Farm Credit Act of 1971 (12 USC 2001 et seq.); or

(C) Institutions chartered by the United States 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 such institutions do not sell or transfer nonpublic personal financial information to a nonaffiliated third party;

(13) "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 federal Bank Holding Company Act of 1956 (12 USC 1843(k)). Financial product or service includes, but is not limited to, 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;

(14) "Former customer" means an individual with whom a licensee no longer has a continuing relationship. A licensee no longer has a continuing relationship with an individual if, for example:

(A) The individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

(B) 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 regulation, or promotional materials;

(C) 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; or

(D) 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;

(15) "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:

(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; or

(C) Payment for the provision of health care to an individual;

(16) "Health Care provider" means a "health care provider" as defined in section 20-7f of the Connecticut General Statutes or a "provider" as defined in section 20-7b of the Connecticut General Statutes;

(17) "Information lawfully made available to the general public" includes, but is not limited to:

(A) Publicly available information in government records including information in government real estate records and security interest filings; or

(B) Publicly available information from a widely distributed media source including information from a telephone book, a television or radio program, a newspaper, or a 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;

(18) "Insurance product or service" means any product or service that is offered by a licensee pursuant to Title 38a of the Connecticut General Statutes. "Insurance product or service" includes, but is not limited to 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;

(19) "Licensee" means any licensed insurers, producers, or other persons licensed, required to be licensed, authorized, required to be authorized, registered, or required to be registered pursuant to Title 38a of the Connecticut General Statutes. "Licensee" includes, but is not limited to an unauthorized insurer that places business through a licensed surplus lines broker in this state, but only in regard to the surplus line placements placed pursuant to section 38a-794 of the Connecticut General Statutes. "Licensee" also includes, but is not limited to 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 section 38a-794 of the Connecticut General Statutes;

(20) "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 (but "nonaffiliated third party" includes the other company that jointly employs the person). "Nonaffiliated third party" includes, but is not limited to 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 of the type described in section 4(k)(4)(H) of the federal Bank Holding Company Act (12 USC 1843(k)(4)(H)) or insurance company investment activities of the type described in section 4(k)(4)(I) of the federal Bank Holding Company Act (12 USC 1843(k)(4)(I));

(21) ‘‘Nonpublic personal financial information’’

(A) Means personally identifiable financial information; or

(B) Means 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 but not limited to any list of individuals’ names and street addresses derived using any personally identifiable financial information that is not publicly available information, such as account numbers;

(C) Shall not include:

(i) Health information;

(ii) Publicly available information, except as included on a list, description, or other grouping of consumers described in subparagraph (B) of this subdivision; or

(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; or

(iv) 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;

(22) ‘‘Personally identifiable financial information’’

(A) Means any information a consumer provides to a licensee to obtain an insurance product or service from the licensee;

(B) Means any information about a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer;

(C) Means any information the licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer;

(D) Includes, but is not limited to, information a consumer provides to a licensee on an application to obtain an insurance product or service;

(E) Includes, but is not limited to, account balance information and payment history;

(F) Includes, but is not limited to, 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;

(G) Includes, but is not limited to, 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;

(H) Includes, but is not limited to, any information that a consumer provides to a licensee or that the licensee or the licensee’s agent otherwise obtains in connection with collecting on a loan or servicing a loan;

(I) Includes, but is not limited to, any information the licensee collects through an Internet cookie (an information-collecting device from a web server);

(J) Includes, but is not limited to, information from a consumer report;

(K) Shall not include health information;

(L) Shall not include a list of names and addresses of customers of an entity that is not a financial institution; and

(M) Shall not include 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;

(23) “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 made to the general public that are required by federal, state, or local law;

(24) “Reasonable basis”

(A) Means a licensee reasonably believes that the information is lawfully made available to the general public when the licensee has taken steps to determine:

(i) That the information is of a type and nature that is available to the general public; and

(ii) 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) Includes, but is not limited to when a licensee, for the purpose of determining that mortgage information is lawfully made available to the general public, has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded;

(C) Includes, but is not limited to when a licensee, for the purpose of determining that an individual’s telephone number is lawfully made available to the general public, has determined whether the licensee has located the telephone number in the telephone book or the consumer has informed the licensee that the telephone number is not unlisted;

(25) “Reasonably understandable” means that the notice:

(A) Presents the information in the notice in clear, concise sentences, paragraphs, or sections;

(B) Uses short explanatory sentences or bullet lists whenever possible;

(C) Uses definite, concrete, everyday words and active voice whenever possible;

(D) Avoids multiple negatives;

(E) Avoids legal and highly technical business terminology whenever possible; and

(F) Avoids explanations that are imprecise and readily subject to different interpretations; and

(26) “To call attention to the nature and significance of the information” means the notice:

(A) Uses a plain-language heading to call attention to the notice;

(B) Uses a font and type size that are easily read;

(C) Provides wide margins and ample line spacing;

(D) Uses boldface or italics for key words;

(E) If 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; and

(F) If on a web page, the notice shall contain text or visual cues to encourage scrolling down the page if necessary to view the entire notice (such as text, graphics, hyperlinks, or sound). The licensee calls attention to the nature and significance of the information on its website if the licensee either:

(i) Places the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or

(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.

(Adopted effective June 7, 2002)

Sec. 38a-8-107. Initial privacy notice to consumers required

(a) A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to:

(1) 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 section 38a-8-117 or section 38a-8-118 of the Regulations of Connecticut State Agencies; and to

(2) An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in subsection (d) of this section. A licensee establishes a customer relationship when the licensee and the consumer enter into a continuing relationship such as when the consumer:

(A) 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 broker, obtains insurance through that licensee; or

(B) Agrees to obtain financial, economic, or investment advisory services relating to insurance products or services for a fee from the licensee.

(b) A licensee is not required to provide an initial notice to a consumer under subsection (a)(1) of this section if:

(1) The licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by section 38a-8-117 or section 38a-8-118 of the Regulations of Connecticut State Agencies, and the licensee does not have a customer relationship with the consumer; or

(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) 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) of this section as follows:

(1) The licensee provides a revised policy notice as set forth in section 38a-8-111 of the Regulations of Connecticut State Agencies 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.

(d) A licensee may provide the initial notice required by subsection (a)(1) of this section within a reasonable time after the licensee establishes a customer relationship if:

(1) Establishing the customer relationship is not at the customer's election, including, but not limited to when 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; or

(2) 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 including, but not limited to 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 or 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 website.

(Adopted effective June 7, 2002)

Sec. 38a-8-108. Annual privacy notice to customers required

(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. Annually means at least once in any period of twelve consecutive months during which that customer relationship exists. A licensee may define the twelve-consecutive-month period, but the licensee shall apply it to the customer on a consistent basis. A licensee provides a notice annually if it defines the twelve-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.

(b) A licensee is not required to provide an annual notice to a former customer.

(c) When a licensee is required by this section to deliver an annual privacy notice, the licensee shall deliver it according to section 38a-8-112 of the Regulations of Connecticut State Agencies.

(Adopted effective June 7, 2002)

Sec. 38a-8-109. Information to be included in privacy notices

(a) The initial, annual, and revised privacy notices that a licensee provides as set forth in section 38a-8-107, section 38a-8-108, and section 38a-8-111 of the Regulations of Connecticut State Agencies shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that apply 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 as set forth in section 38a-8-117 or section 38a-8-118 of the Regulations of Connecticut State Agencies;

(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 as set forth in section 38a-8-117 or section 38a-8-118 of the Regulations of Connecticut State Agencies;

(5) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party as set forth in section 38a-8-116 of the Regulations of Connecticut State Agencies (and no other exception in section 38a-8-117 or section 38a-8-118 of the Regulations of Connecticut State Agencies 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 as set forth in section 38a-8-113 of the Regulations of Connecticut State Agencies 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 as set forth in section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 USC 1681a(d)(2)(A)(iii)) (that is, notices 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 financial information; and

(9) Any disclosure that the licensee makes as set forth in subsection (b) of this section.

(b) If a licensee discloses nonpublic personal financial information as authorized by section 38a-8-117 or section 38a-8-118 of the Regulations of Connecticut State Agencies, the licensee is not required to list those exceptions in the initial, annual, or revised privacy notices required by section 38a-8-107, section 38a-8-108, or section 38a-8-111 of the Regulations of Connecticut State Agencies. 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) A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes the information according to the source of the information, as applicable, for example:

(1) Information from the consumer;

(2) Information about the consumer's transactions with the licensee or the licensee's affiliates;

(3) Information about the consumer's transactions with nonaffiliated third parties; and

(4) Information from a consumer reporting agency.

(d) 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 subsection (c) of this section, as applicable, and provides a few examples to illustrate the types of information in each category. Examples may include:

(1) Information from the consumer, including application information such as assets and income, and identifying information such as name, address, and social security number;

(2) Specific transaction information, such as information about balances, payment history, and parties to the transaction; and

(3) Information from consumer reports, such as a consumer's creditworthiness and credit history.

(e) 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."

(f) 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 financial information that the licensee discloses.

(g) 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. Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. 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.

(h) If a licensee discloses nonpublic personal financial information authorized by section 38a-8-116 of the Regulations of Connecticut State Agencies 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) of this section if it:

(1) 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) of this section, as applicable; and

(2) States whether the third party is:

(A) A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(B) A financial institution with whom the licensee has a joint marketing agreement.

(i) 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 section 38a-8-117 or section 38a-8-118 of the Regulations of Connecticut State Agencies, the licensee may simply state that fact, in addition to the information it shall provide as set forth in section 38a-8-109(a)(1), section 38a-8-109(a)(8), section 38a-8-109(a)(9), and section 38a-8-109(b) of the Regulations of Connecticut State Agencies.

(j) A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it:

(1) Describes in general terms who is authorized to have access to the information; and

(2) 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 that it utilizes.

(k) A licensee may satisfy the initial notice requirements in section 38a-8-107(a)(2) and section 38a-8-110(g) of the Regulations of Connecticut State Agencies 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 38a-8-110 of the Regulations of Connecticut State Agencies. The licensee shall deliver its short-form initial notice in accordance with section 38a-8-112 of the Regulations of Connecticut State Agencies. 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 in accordance with section 38a-8-112 of the Regulations of Connecticut State Agencies. A short-form initial notice shall:

(1) Be clear and conspicuous;

(2) State that the licensee's privacy notice is available upon request; and

(3) Explain a reasonable means by which the consumer may obtain that notice.

(l) The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee, for example:

(1) Provides a toll-free telephone number that the consumer may call to request the notice; or

(2) 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.

(m) The licensee's notice may include:

- (1) Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but does not currently disclose; and
- (2) Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

(Adopted effective June 7, 2002)

Sec. 38a-8-110. Form of opt out notice to consumers and opt out methods

(a) If a licensee is required to provide an opt out notice as set forth in section 38a-8-113(a) of the Regulations of Connecticut State Agencies, it shall provide a clear and conspicuous notice to each of its consumers that accurately explains that right to opt out. The opt out notice shall:

- (1) State that the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;
- (2) State that the consumer has the right to opt out of that disclosure; and
- (3) Provide a reasonable means by which the consumer may exercise the opt out right.

(b) 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:

(1) 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 38a-8-109(a)(2) and section 38a-8-109(a)(3) of the Regulations of Connecticut State Agencies, and states that the consumer can opt out of the disclosure of that information; and

(2) 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.

(c) A licensee provides a reasonable means to exercise an opt out right if it:

- (1) Designates check-off boxes in a prominent position on a reply form(s);
- (2) Includes a reply form together with the opt out notice;
- (3) 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; or

(4) Provides a toll-free telephone number that consumers may call to opt out.

(d) A licensee does not provide a reasonable means to opt out if:

(1) The only means to opt out is for the consumer to write his or her own letter to exercise that opt out right; or

(2) The only means to opt out as described in any notice subsequent to the initial notice is to use a check-off box on a reply form that the licensee provided with the initial notice but did not include with the subsequent notice.

(e) A licensee may require each consumer to opt out through a specific means, as long as that means is reasonable for that consumer.

(f) 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 38a-8-107 of the Regulations of Connecticut State Agencies.

(g) If a licensee provides the opt out notice later than required for the initial notice in accordance with section 38a-8-107 of the Regulations of Connecticut State Agencies, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

(h) If two 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. Any of the joint consumers may exercise the right to opt out. The licensee may:

(1) Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

(2) Permit each joint consumer to opt out separately.

(i) If a licensee permits each joint consumer to opt out separately, the licensee shall permit one of the joint consumers to opt out on behalf of all of the joint consumers.

(j) A licensee may not require all joint consumers to opt out before it implements any opt out direction.

(k) A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it.

(l) A consumer may exercise the right to opt out at any time.

(m) A consumer's direction to opt out as set forth in this section is effective until the consumer revokes it in writing or, if the consumer agrees, electronically.

(n) When a customer ceases to have a continuing relationship with a licensee, 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 former customer establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship shall not apply to the new relationship.

(o) A surplus lines broker or surplus lines insurer shall be deemed to be in compliance with initial notice in section 38a-8-107 of the Regulations of Connecticut State Agencies, the annual notice in section 38a-8-108 of the Regulations of Connecticut State Agencies, the revised notice in section 38a-8-111 of the Regulations of Connecticut State Agencies, and opt out in section 38a-8-110 and 38a-8-113 of the Regulations of Connecticut State Agencies if:

(1) The surplus lines broker or surplus lines insurer does not disclose nonpublic personal financial information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing as set forth in section 38a-8-116 of the Regulations of Connecticut State Agencies, except as permitted by section 38a-8-117 or 38a-8-118 of the Regulations of Connecticut State Agencies; and

(2) The surplus lines broker or surplus lines 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. BROKERS THAT HANDLED THIS INSURANCE NOR THE INSURERS THAT HAVE UNDERWRITTEN THIS INSURANCE WILL DISCLOSE NONPUBLIC PERSONAL FINANCIAL INFORMATION CONCERNING THE BUYER TO NONAFFILIATES OF THE BROKERS OR INSURERS EXCEPT AS PERMITTED BY LAW.

(Adopted effective June 7, 2002)

Sec. 38a-8-111. Revised privacy notices

(a) Except as otherwise permitted by section 38a-8-116, 38a-8-117, or 38a-8-118 of the Regulations of Connecticut State Agencies, 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 as set forth in section 38a-8-107 of the Regulations of Connecticut State Agencies, unless:

(1) The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

(2) The licensee has provided to the consumer a new opt out notice;

(3) The 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) The consumer does not opt out.

(b) Except as otherwise permitted by section 38a-8-116, 38a-8-117, or 38a-8-118 of the Regulations of Connecticut State Agencies, a licensee shall provide a revised notice before it:

(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; or

(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.

(Adopted effective June 7, 2002)

Sec. 38a-8-112. Delivery

(a) A licensee shall provide all notices that sections 38a-8-105 to 38a-8-123 of the Regulations of Connecticut State Agencies require 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:

(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, however, reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it:

(1) Only posts a sign in its office or generally publishes advertisements of its privacy policies and practices; or

(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:

(1) The customer 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) The customer 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 shall not provide any notice required by sections 38a-8-105 to 38a-8-123 of the Regulations of Connecticut State Agencies 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 38a-8-107(a)(1) of the Regulations of Connecticut State Agencies, the annual notice required by section 38a-8-108(a) of the Regulations of Connecticut State Agencies, and the revised notice required by section 38a-8-111 of the Regulations of Connecticut State Agencies 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, for example:

(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; or

(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 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 financial institutions. A licensee also may provide a notice on behalf of another financial institution.

(h) If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial notice requirements in section 38a-8-107 of the Regulations of Connecticut State Agencies, the annual notice requirements in section 38a-8-108 of the Regulations of Connecticut State Agencies, and the revised notice requirements in section 38a-8-111 of the Regulations of Connecticut State Agencies, respectively, by providing one notice to those consumers jointly.

(i) A licensee shall provide any notice required by section 38a-8-107, 38a-8-108, 38a-8-110, 38a-8-111, or 38a-8-113 of the Regulations of Connecticut State Agencies, and notices required by section 38a-975 to 38a-998 of the Connecticut General Statutes, through the use of separate notices or a combined notice, so long as the notices are clear and conspicuous.

(Adopted effective June 7, 2002)

Sec. 38a-8-113. Limits on disclosure of nonpublic personal financial information to nonaffiliated third parties

(a) Except as otherwise authorized in sections 38a-8-105 to 38a-8-123 of the Regulations of Connecticut State Agencies, a licensee shall not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless:

(1) The licensee has provided to the consumer an initial notice as set forth in section 38a-8-107 of the Regulations of Connecticut State Agencies;

(2) The licensee has provided to the consumer an opt out notice as required in section 38a-8-110 of the Regulations of Connecticut State Agencies;

(3) The 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) The consumer does not opt out. "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 section 38a-8-116, 38a-8-117, or 38a-8-118 of the Regulations of Connecticut State Agencies.

(b) A licensee provides a consumer with a reasonable opportunity to opt out if:

(1) The licensee mails the notices required 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 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 electronically, and the licensee allows the customer to opt out by any reasonable means within thirty days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account.

(c) 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 at the time of the transaction and requests that the customer 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.

(e) 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.

(f) 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.

(Adopted effective June 7, 2002)

Sec. 38a-8-114. Limits on redisclosure and reuse of nonpublic personal financial information

(a) If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in section 38a-8-117 or 38a-8-118 of the Regulations of Connecticut State Agencies, 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; and

(3) The licensee may disclose and use the information pursuant to an exception in section 38a-8-117 or 38a-8-118 of the Regulations of Connecticut State Agencies in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

(b) 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.

(c) If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in section 38a-8-117 or section 38a-8-118 of the Regulations of Connecticut State Agencies, the licensee may disclose the information only:

(1) To the affiliates of the financial institution from which the licensee received the information;

(2) To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

(3) To 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.

(d) If a licensee obtains a customer list from a nonaffiliated financial institution outside of the exceptions in section 38a-8-117 or section 38a-8-118 of the Regulations of Connecticut State Agencies:

(1) The licensee may use that list for its own purposes; and

(2) 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 38a-8-117 or 38a-8-118 of the Regulations of Connecticut State Agencies, such as to the licensee's attorneys or accountants.

(e) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in section 38a-8-117 or 38a-8-118 of the Regulations of Connecticut State Agencies, 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; and

(3) The third party may disclose and use the information pursuant to an exception in section 38a-8-117 or 38a-8-118 of the Regulations of Connecticut State Agencies, in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

(f) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in section 38a-8-117 or 38a-8-118 of the Regulations of Connecticut State Agencies, the third party may disclose the information only:

(1) To the licensee's affiliates;

(2) To 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) To any other person, if the disclosure would be lawful if the licensee made it directly to that person.

(Adopted effective June 7, 2002)

Sec. 38a-8-115. Limits on sharing account number information for marketing purposes

(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) of this section shall not apply if a licensee discloses a policy number or similar form of access number or access code:

(1) To 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) To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services.

(3) To a participant in an affinity 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 the 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.

(Adopted effective June 7, 2002)

Sec. 38a-8-116. Exception to opt out requirements for disclosure of nonpublic personal financial information for service providers and joint marketing

(a) The opt out requirements in sections 38a-8-110 and 38a-8-113 of the Regulations of Connecticut State Agencies shall 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 38a-8-107 of the Regulations of Connecticut State Agencies; 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 38a-8-117 or 38a-8-118 of the Regulations of Connecticut State Agencies, in the ordinary course of business to carry out those purposes.

(b) If a licensee discloses nonpublic personal financial information as set forth in this section to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that financial institution meets the requirements of subsection (a)(2) of this section if it prohibits the financial 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 38a-8-117 or 38a-8-118 of the Regulations of Connecticut State Agencies, in the ordinary course of business to carry out that joint marketing.

(c) The services a nonaffiliated third party performs for a licensee 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 or more financial institutions.

(d) For purposes of this section, “joint agreement” means a written contract pursuant to which a licensee and one or more financial institutions jointly offer, endorse, or sponsor a financial product or service.

(Adopted effective June 7, 2002)

Sec. 38a-8-117. Exceptions to notice and opt out requirements for disclosure of nonpublic personal financial information for processing and servicing transactions

(a) The requirements for the initial notice in section 38a-8-107 of the Regulations of Connecticut State Agencies, the annual notice in section 38a-8-108 of the Regulations of Connecticut State Agencies, the revised notice in section 38a-8-111 of the Regulations of Connecticut State Agencies, and opt out in section 38a-8-110 and 38a-8-113 of the Regulations of Connecticut State Agencies do not apply if the licensee:

(1) Is an employee, agent, or other representative of another licensee (“the principal”) including, but not limited to:

(A) An insurance broker, public adjuster, or other licensee who is employed by another insurance broker, public adjuster, or other licensee;

(B) An independent adjuster adjusting a claim or benefit on behalf of an insurer;

(C) An insurance agent of an insurer;

(D) An insurance broker that has binding authority for an insurer; or

(E) A sublicensee of a licensee, whether or not the sublicensee is licensed in any other capacity; and

(2) The principal otherwise complies with, and provides the notices required by sections 38a-8-105 to 38a-8-123 of the Regulations of Connecticut State Agencies; and

(3) The licensee does not disclose any nonpublic personal financial information to any person other than the principal or the principal’s affiliates in a manner permitted by sections 38a-8-105 to 38a-8-123 of the Regulations of Connecticut State Agencies.

(b) The requirements for the initial notice in section 38a-8-107 of the Regulations of Connecticut State Agencies, the opt out in sections 38a-8-110 and 38a-8-113 of the Regulations of Connecticut State Agencies, and requirements for service providers and joint marketing in section 38a-8-116 of the Regulations of Connecticut State Agencies shall 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:

(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; or

(4) Reinsurance or stop loss or excess loss insurance.

(c) The disclosure of nonpublic personal financial information shall be deemed necessary to effect, administer, or enforce a transaction if disclosure is:

(1) Required, or is one 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; or

(2) Required, usual, appropriate, or an acceptable method:

(A) To carry out the transaction or the product, to service business of which the transaction is a part, to record, service, or maintain the consumer's account in the ordinary course of providing the insurance product or service;

(B) To administer or service benefits or claims relating to the transaction or the product, or to service business of which it is a part;

(C) To 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, the consumer's agent, broker, or to the policyholder of a worker's compensation plan;

(D) To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party;

(E) To underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer's insurance: account administration, reporting, investigating or preventing fraud or material misrepresentation, processing premium payments, processing insurance claims, administering insurance benefits (including utilization review activities), participating in research projects, or as otherwise required or specifically permitted by federal or state law; or

(F) In connection with:

(i) The 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;

(ii) The transfer of receivables, accounts, or interests therein; or

(iii) The audit of debit, credit, or other payment information.

(Adopted effective June 7, 2002)

Sec. 38a-8-118. Other exceptions to initial notice and opt out requirements for disclosure of nonpublic personal financial information

(a) The requirements for initial notice to consumers in section 38a-8-107 of the Regulations of Connecticut State Agencies, the opt out in sections 38a-8-110 and 38a-8-113 of the Regulations of Connecticut State Agencies, and requirements for service providers and joint marketing in section 38a-8-116 of the Regulations of Connecticut State Agencies shall not apply when a licensee discloses nonpublic personal financial information:

(1) With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction;

(2) To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product, or transaction;

(3) To protect against or prevent actual or potential fraud or unauthorized transactions;

(4) For institutional risk control required by applicable law or for resolving consumer disputes or inquiries;

(5) To persons holding a legal or beneficial interest relating to the consumer;

(6) To persons acting in a fiduciary or representative capacity on behalf of the consumer;

(7) To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, the licensee's attorneys, accountants, or auditors;

(8) To the extent specifically permitted or required under other provisions of law and in accordance with the federal Right to Financial Privacy Act of 1978 (12 USC 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 USC Chapter 53, Subchapter II (Records and Reports on Monetary Instruments and Transactions) and 12 USC 21 (Financial Record keeping), a state insurance authority, the Federal Trade Commission, self-regulatory organizations, or for an investigation on a matter related to public safety;

(9) To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act (15 USC 1681 et seq.); or from a consumer report reported by a consumer reporting agency;

(10) 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;

(11) To comply with federal, state, or local laws, rules, and other applicable legal requirements;

(12) To comply with a properly authorized civil, criminal, or regulatory investigation, subpoena, or summons by federal, state, or local authorities;

(13) To respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance, or other purposes as authorized by law; or

(14) For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan, or workers' compensation plan.

(b) A consumer may revoke consent by subsequently exercising the right to opt out of future disclosures of nonpublic personal financial information as permitted under section 38a-8-110(l) of the Regulations of Connecticut State Agencies.

(c) Licensees in liquidation or receivership are not subject to the notice provisions of section 38a-8-107, section 38a-8-108, section 38a-8-110, and section 38a-8-111 of the Regulations of Connecticut State Agencies.

(Adopted effective June 7, 2002)

Sec. 38a-8-119. Protection of federal fair credit reporting act

Nothing in sections 38a-8-105 to 38a-8-123 of the Regulations of Connecticut State Agencies shall be construed to modify, limit, or supersede the operation of the federal Fair Credit Reporting Act (15 USC 1681 et seq.), and no inference shall be drawn on the basis of the provisions of the Regulations of Connecticut State Agencies regarding whether information is transaction or experience information as set forth in section 603 of the federal Fair Credit Reporting Act.

(Adopted effective June 7, 2002)

Sec. 38a-8-120. Nondiscrimination

A licensee does not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of their nonpublic personal financial information pursuant to the provisions of sections 38a-8-105 to 38a-8-123 of the Regulations of Connecticut State Agencies.

(Adopted effective June 7, 2002)

Sec. 38a-8-121. Rules for health information

A licensee shall comply with all applicable state and federal statutes and regulations to protect the confidentiality of health information.

(Adopted effective June 7, 2002)

Sec. 38a-8-122. Effective date and compliance

(a) 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 provisions of section 38a-8-116(a)(2) of the Regulations of Connecticut State Agencies, even if the contract does not include a requirement that the third party maintain the confidentiality of nonpublic personal financial information, as long as the licensee entered into the agreement on or before the date sections 38a-8-105 to 38a-8-123 of the Regulations of Connecticut State Agencies becomes effective.

(b) The examples and sample clauses included in sections 38a-8-105 to 38a-8-123 of the Regulations of Connecticut State Agencies and Appendix to sections 38a-8-105 to 38a-8-123 of the Regulations of Connecticut State Agencies are not exclusive. Compliance with an example or use of a sample clause, to the extent applicable, constitutes compliance with sections 38a-8-105 to 38a-8-123 of the Regulations of Connecticut State Agencies.

(Adopted effective June 7, 2002)

Sec. 38a-8-123. Severability

If any portion of sections 38a-8-105 to 38a-8-123 of the Regulations of Connecticut State Agencies or its applicability to any person or circumstance is held invalid by a court, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

APPENDIX A-Sample Clauses

Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. (Note that disclosure of certain information, such as assets, income, and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

A-1-Categories of information a licensee collects (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of section 38a-8-109(a)(1) of the Regulations of Connecticut State Agencies to describe the categories of nonpublic personal financial information the licensee collects.

Sample Clause A-1:

We collect nonpublic personal financial information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates or others; and
- Information we receive from a consumer reporting agency.

A-2-Categories of information a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use one of these clauses, as applicable, to meet the requirement of section 38a-8-109(a)(2) of the Regulations of Connecticut State Agencies to describe the categories of nonpublic personal financial information the licensee discloses. The licensee may use these clauses if it discloses nonpublic personal financial information other than as permitted by exception.

Sample Clause A-2, Alternative 1:

We may disclose the following kinds of nonpublic personal financial information about you:

- 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”];
- Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as “your policy coverage, premiums, and payment history”]; and
- Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as “your creditworthiness and credit history”].

Sample Clause A-2, Alternative 2:

We may disclose all of the information that we collect, as described [describe location in the notice, such as “above” or “below”].

A-3—Categories of information a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirements of section 38a-8-109(a)(2), (3), and (4) of the Regulations of Connecticut State Agencies to describe the categories of nonpublic personal financial 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 this clause if the licensee does not disclose nonpublic personal financial information to any party, other than as permitted.

Sample Clause A-3:

We do not disclose any nonpublic personal financial information about our customers or former customers to anyone, except as permitted by law.

A-4—Categories of parties to whom a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirement of section 38a-8-109(a)(3) to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information. This clause may be used if the licensee discloses nonpublic personal financial information other than as permitted.

Sample Clause A-4:

We may disclose nonpublic personal financial information about you to the following types of third parties:

- Financial service providers, such as [provide illustrative examples, such as “life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents”];
 - Non-financial companies, such as [provide illustrative examples, such as “retailers, direct marketers, airlines, and publishers”]; and
 - Others, such as [provide illustrative examples, such as “non-profit organizations”].
- We may also disclose nonpublic personal financial information about you to nonaffiliated third parties as permitted by law.

A-5—Service provider/joint marketing exception

A licensee may use one of these clauses, as applicable, to meet the requirements of section 38a-8-109(a)(5) of the Regulations of Connecticut State Agencies. If a licensee discloses nonpublic personal financial information under this exception, the licensee shall describe the categories of nonpublic personal financial information

the licensee discloses and the categories of third parties with whom the licensee has contracted.

Sample Clause A-5, Alternative 1:

We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements:

- 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”];
- Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as “your policy coverage, premium, and payment history”]; and
- Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as “your creditworthiness and credit history”].

Sample Clause A-5, Alternative 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.

A-6—Explanation of opt out right (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirement of section 38a-8-109(a)(6) of the Regulations of Connecticut State Agencies to provide an explanation of the consumer’s right to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the method(s) by which the consumer may exercise that right. The licensee may use this clause if the licensee discloses nonpublic personal financial information other than as permitted.

Sample Clause A-6:

If you prefer that we 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 permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, you may [describe a reasonable means of opting out, such as “call the following toll-free number: (insert number)”].

A-7—Confidentiality and security (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of section 38a-8-109(a)(8) of the Regulations of Connecticut State Agencies to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information.

Sample Clause A-7:

We restrict access to nonpublic personal financial 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 financial information.

(Adopted effective June 7, 2002)

Safeguarding Customer Financial Information

Sec. 38a-8-124. Definitions

As used in sections 38a-8-124 to 38a-8-126, inclusive, of the Regulations of Connecticut State Agencies:

(1) “Customer” means “customer” as defined in section 38a-8-106 of the Regulations of Connecticut State Agencies.

(2) “Customer information” means “nonpublic personal financial information” as defined in section 38a-8-106 of the Regulations of Connecticut State Agencies, about a customer, whether in paper, electronic, or other form that is maintained by or on behalf of the licensee.

(3) “Customer information systems” means the methods used to access, collect, store, use, transmit, protect or dispose of customer information, and includes, but is not limited to, an “information processing system” as defined in section 1-267 of the Connecticut General Statutes.

(4) “Licensee” means “licensee” as defined in section 38a-8-106 of the Regulations of Connecticut State Agencies.

(5) “Service provider” means a person that provides services to the licensee and maintains, processes or otherwise is permitted access to customer information.

(Adopted effective January 1, 2004)

Sec. 38a-8-125. Information security program

Each licensee shall implement a comprehensive written information security program that includes administrative, technical and physical safeguards for the protection of customer information that are appropriate to the size and complexity of the licensee and the nature and scope of its activities. Each information security program shall be designed to: ensure the security and confidentiality of customer information; protect against any anticipated threats or hazards to the security or integrity of customer information; and protect against unauthorized access to, or use of, customer information that could result in substantial harm or inconvenience to any customer.

(Adopted effective January 1, 2004)

Sec. 38a-8-126. Developing and implementing an information security program

The actions and procedures described in this section are examples of methods of implementation of the requirements of section 38a-8-125 of the Regulations of Connecticut State Agencies. These examples are non-exclusive illustrations of actions and procedures that licensees may follow to implement section 38a-8-125 of the Regulations of Connecticut State Agencies.

(1) The licensee identifies reasonably foreseeable internal or external threats that could result in unauthorized disclosure, misuse, alteration or destruction of customer information or customer information systems. The licensee assesses the likelihood and potential damage of the risks presented by the threats it has identified, taking into consideration the sensitivity of customer information. The licensee assesses the sufficiency of the policies and procedures it has in place to control the risks it has identified.

(2) The licensee designs its information security program to control the identified risks, commensurate with the sensitivity of the information and the complexity and scope of the licensee’s activities. The licensee trains staff, as appropriate, to implement the licensee’s information security program and regularly tests or otherwise

regularly monitors the key controls, systems and procedures of its information security program. The frequency and nature of these tests or other monitoring practices are determined by the licensee's risk assessment.

(3) The licensee exercises due diligence in selecting service providers, and requires its service providers to implement measures designed to meet the objectives of section 38a-8-125 of the Regulations of Connecticut State Agencies and takes appropriate steps to confirm that its service providers have done so.

(4) The licensee monitors, evaluates and adjusts, as appropriate, its information security program to reflect any relevant changes in technology, the sensitivity of its customer information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements and changes to its customer information systems.

(Adopted effective January 1, 2004)

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Arbitration Procedure for Automobile Physical Damage and Property Damage Claims

Sec. 38a-10-1. Applicability

This regulation shall apply to any person engaged in the settlement of claims with respect to first party motor vehicle physical damage claims and third party property damage liability claims of residents of this state arising under an insurance policy insuring a private passenger motor vehicle when coverage and liability are not in dispute.

(Effective September 25, 1992)

Sec. 38a-10-2. Definitions

As used in this regulation:

(a) "Arbitration" means the process in which each party presents its case at a hearing to the arbitrator for a final decision.

Arbitration may be conducted, at the option of the claimant, either upon the submission of documents to the arbitrator or at an oral hearing.

(b) "Arbitrator" means a person selected by the Commissioner in accordance with subsection (b) of Section 38a-9 of the General Statutes to hear and decide disputes between a claimant and an insurance company concerning automobile physical damage and automobile property damage liability claims in which liability and coverage are not in dispute.

(c) "Claimant" means any person who attempts to obtain a benefit from his insurer in relation to a first party automobile physical damage claim or presents a third party claim against an insured for property damage liability to his private passenger motor vehicle, when liability and coverage are not in dispute.

(d) "Commissioner" means the Insurance Commissioner of this state.

(e) "Insurer" or "insurance company" means any insurance company licensed by the Commissioner to write automobile liability insurance or automobile physical damage insurance.

(f) "Loss of Use" means the amount representing the reasonable value to the claimant for the deprivation of the use of the claimant's vehicle during the period reasonably required to make repairs or replace the vehicle, regardless of whether the claimant has incurred expenses.

(g) "Private passenger motor vehicle" means motor vehicles as defined in subsection (g) of Section 38a-363 of the General Statutes.

(h) "Storage" means the holding of a vehicle at a place designated under Section 14-66 of the General Statutes for a specific rate which has been filed with the Commissioner of Motor Vehicles.

(Effective September 25, 1992)

Sec. 38a-10-3. Arbitration procedure

(a) If mediation by the Insurance Department Division of Consumer Affairs fails to resolve a dispute between a claimant and an insurance company, the Insurance Department examiner who examined the complaint shall refer the file to the Arbitration Unit of the Insurance Department to begin the arbitration procedure.

(b) The Arbitration Unit shall notify the claimant by a form prepared by the Insurance Department that the claim is arbitrable which shall be sent within five (5) business days from date of referral. The form which shall include a request for arbitration shall be returned to the Arbitration Unit of the Insurance Department within fourteen (14) calendar days together with a non-refundable check for the

\$20.00 filing fee made payable to the Treasurer, State of Connecticut. The claimant shall indicate whether the arbitration will be by submission of documents or by oral hearing.

(c) Failure of the claimant to return the request for arbitration form within fourteen (14) calendar days shall automatically cancel the proceedings. The claimant, with prior written approval of the Insurance Department Arbitration Unit, may be granted a reasonable delay in filing for arbitration.

(d) Upon receipt of the request for arbitration form, the Arbitration Unit shall submit the written notice of arbitration to the insurer, advising whether the arbitration will be conducted by submission of documents or by oral hearing. The insurer shall return a non-refundable check for \$20.00 made payable to the Treasurer, State of Connecticut and a copy of its file within fourteen (14) calendar days. The insurer must pay the claimant the undisputed amount within five (5) business days of the receipt of the notice of arbitration.

(e) Failure of the insurance company or its designated adjusting company to respond within fourteen (14) calendar days of the mailing of the notice shall allow the arbitrator to enter an award in favor of the claimant for all or part of the disputed damages and a check shall be issued for all or part of the disputed amount by the insurer within ten (10) business days of the date of the award.

(f) The Arbitration Unit shall: (A) notify the arbitrator in writing of the date, time and location of the hearing within ten (10) business days from the receipt of the insurer's response or upon the expiration of the fourteen (14) days specified in subsection (e) of this section, whichever is earlier; and (B) notify the claimant and the insurer in writing of the arbitrator's name, the date, time and location of the hearing at least ten (10) business days prior to the hearing. If upon such notice either party has a reasonable objection to the selected arbitrator then that party must notify the Arbitration Unit of its objection within three (3) business days prior to the hearing date. The hearing will be rescheduled with another arbitrator selected in rotation from the panel of arbitrators.

(g) Within fifteen (15) days following the hearing the arbitrator shall issue a written decision based on the information gathered and disclosing the findings and the reasons for the findings to the parties involved.

(h) The arbitrator may request the Insurance Commissioner to issue subpoenas on behalf of the arbitrator to compel the attendance of witnesses and the production of documents, papers and records relevant to the dispute. When the arbitrator believes technical assistance is necessary to decide a case, he may consult with an independent expert recommended by the Insurance Commissioner.

(i) Decisions favoring the complainant, which may include loss of use and storage, shall be paid within ten (10) business days of the receipt of the decision and shall include interest on the arbitration award at a rate of ten percent (10%) computed by dividing the number 365 into ten percent (10%) multiplied by the number of days between the date of payment for the undisputed amount of the claim and the date of issuance of the award.

(Effective September 25, 1992)

Sec. 38a-10-4. Records

(a) The Insurance Department shall maintain a record of each arbitration which shall include the docket number, names of the parties involved, decision of the arbitrator, and information concerning compliance and judicial review of the decision.

(b) The Insurance Department shall annually compile a report on the arbitration proceedings and send a copy to the committee of the Connecticut General Assembly having cognizance of “matters relating to insurance.” The public shall have the right to inspect such report during regular business hours of the Insurance Department or receive a copy of it in accordance with Section 1-15 of the General Statutes.

(Effective September 25, 1992)

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Requirements for Insurance Companies Applying for a License to do Business in the State of Connecticut

Sec. 38a-41-1. Authority

The following regulations are adopted pursuant to section 38a-41 of the General Statutes of Connecticut as amended by section 7 of Public Act 81-101.

(Effective September 25, 1992)

Sec. 38a-41-2. Provisions of regulation

Applicants seeking a Certificate of Authority to do any insurance business in the state of Connecticut shall comply with the provisions of law and this regulation, provided the commissioner may waive the applicability of any section(s) or any portion thereof as to

(a) a survivor corporation resulting from the merger or reorganization of a company licensed in this state,

(b) a company domiciled in this state and

(c) a company which is an affiliate of an insurer licensed in this state, if he determines that particular requirements are unnecessary or the information to be filed is otherwise available.

(Effective September 25, 1992)

Sec. 38a-41-3. General qualifications

Any unlicensed insurance company seeking to solicit or market insurance products in this state is hereby declared subject to Sections 38a-41-1 to 38a-41-4, inclusive, of the Regulations of the Connecticut State Agencies. All companies desiring to become authorized to transact kinds of insurance permitted by title 38a of the Connecticut General Statutes shall submit an application as follows:

(1) Capital and domiciliary licensure requirements.

(A) The applicant shall file an application on the form prescribed by the insurance commissioner setting forth the lines of insurance which it desires to write. For each line of insurance the applicant proposes to write it shall demonstrate that it is possessed of adequate capital and/or surplus funds in a minimum amount as prescribed in title 38a of the Connecticut General Statutes.

(B) A determination of financial condition will be made regarding those companies which apply. In making this determination there shall be deducted from unassigned funds any non-qualifying assets or understatement in reserves or special deposits not held on account for all policyholders. The difference between market value and amortized value of investments in bonds may be taken into consideration and also the ratio of earned premiums to surplus as regards policyholders for non-life companies when the ratio exceeds 3:1, as well as any other ratios that are generally acceptable among regulators and the insurance industry.

(C) Applicant shall hold a valid Certificate of Authority from its state of domicile or jurisdiction which authorizes it to transact those kinds of insurance it proposes to transact in this state.

(2) Historic business experience.

(A) Applicant shall demonstrate an orderly pattern of growth in the company's marketing territories in the geographic region. The commissioner, upon assessment of the rate of growth of the company, its business persistency, supporting surplus resources, business acquisition costs, claims experience and investment policies shall make a determination concerning the adequacy of equity resources as related to the company's business expansion. Such determination, together with a review

of policyholder service arrangements relating to Connecticut residents, will be used to evaluate the company's potential to perform on policy obligations contracted within this state and its expertness in marketing and servicing its product lines.

(B) Applicant shall show that it writes those lines of business in its domiciliary jurisdiction or other license jurisdictions that it proposes to write in this state in sufficient volume as to demonstrate an expertise in marketing and servicing such products lines. This requirement may be waived regarding survivor corporations in the case of mergers or consolidations, or a company which is an affiliate of an insurer licensed in Connecticut if it is determined this requirement is unnecessary.

(3) Specific filing requirements.

Each insurance company shall file applications using the licensing requirements, forms and procedures as set forth in the Uniform Certificate of Authority Application (UCAA), and any supplemental forms promulgated pursuant to the UCAA published by the National Association of Insurance Commissioners, subject to any deviations of form and detail and additional filings as may be prescribed by the commissioner.

(Effective November 25, 1992; amended July 30, 1999, March 10, 2003)

Sec. 38a-41-4. Procedure

(1) As far as practicable, all applicants having been assigned a sequential order respecting their application will have their submission reviewed in that serial order.

(2) Applicants must keep filing current. Any amendments to constituent documents on file must be timely dated.

(3) Any applications whose application is rejected as a result of a review who reapplies will be assigned a new sequential order respecting its application as provided above.

(4) Any applicant whose application is rejected is entitled to a hearing.

(5) Any applicant whose application has been rejected other than as provided in subdivision (6) of this section or who has withdrawn its application may not reapply for a certificate of authority until a minimum of two years has expired. For good cause shown, such waiting period may be waived by the commissioner.

(6) Any applicant after written notice by the insurance department that its application is incomplete or has not been made current shall have its application rejected if the deficiency in the application is not corrected within 30 days of notification.

(Effective November 25, 1992; amended March 10, 2003)

Sec. 38a-41-5. Effective date

These regulations shall take effect on filing with the secretary of state as provided in section 4-172 of the General Statutes.

(Effective September 25, 1992)

Sec. 38a-41-6. Severability

If any section or portion of a section of these regulations or the applicability thereof to any person or circumstances is held invalid by a court, the remainder of the regulations, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

(Effective September 25, 1992)

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Statement of Actuarial Opinion

Sec. 38a-53-1. Definitions

As used in Sections 38a-53-1 to 38a-53-4, inclusive of the Regulations of Connecticut State Agencies:

(a) “Qualified Actuary” and “Qualified Loss Reserve Specialist” means a person who is either:

(1) A member in good standing of the Casualty Actuarial Society; or

(2) A member in good standing of the American Academy of Actuaries who has been approved as qualified for signing casualty loss reserve opinions by the Casualty Practice Council of the American Academy of Actuaries; or

(3) A member in good standing of the Society of Actuaries; or

(4) In the case of a health care center or life and health insurance company, an actuary who is qualified to submit an actuarial opinion regarding a life insurance company’s accident and health reserves in accordance with Section 38a-78 of the General Statutes.

(b) “Annual Statement” means the annual financial statement required to be filed by insurers with the Commissioner pursuant to Section 38a-53 of the General Statutes.

(c) “Appointed Actuary” means a Qualified Actuary who is appointed by the Board of Directors, or its equivalent, of an insurer or health care center, or by a committee of the Board.

(d) “Commissioner” means the Insurance Commissioner of the State of Connecticut.

(e) “Workpapers” means the records which support the conclusions reached by the Qualified Actuary or Qualified Reserve Specialist as to the adequacy of the company’s reserves.

(f) “Insurer”, “Insurance Company”, or “Company” means a health care center or an insurance company (other than a life insurance company) licensed by the Commissioner to do business in this state.

(g) “NAIC” means the National Association of Insurance Commissioners.

(Effective September 28, 1993; amended March 4, 2010)

Sec. 38a-53-2. Statement of actuarial opinion

(a) Each insurer shall include as an attachment to page one of its Annual Statement an opinion of a Qualified Actuary or qualified reserve specialist, entitled “Statement of Actuarial Opinion,” which shall set forth his or her certification as to the adequacy of all reserve liabilities of the company. The Qualified Actuary or reserve specialist shall be appointed by the Board of Directors, or its equivalent, or by a committee of the Board, by December 31 of the calendar year for which the opinion is rendered. Whenever the Appointed Actuary or reserve specialist is replaced by the Board of Directors, the company must notify its domiciliary commissioner within 30 days of the date of the Board action and give the reasons for the replacement. The Appointed Actuary shall present a report to the Board of Directors each year on the items within the scope of the opinion. For good cause shown, the Commissioner may in his discretion, require the Statement of Actuarial Opinion to be prepared by an independent Qualified Actuary or qualified reserve specialist who is not an employee of the company.

(b) Every property and casualty insurance company doing business in this state, unless otherwise exempted by the domiciliary commissioner, shall annually submit the opinion of an Appointed Actuary, entitled “Statement of Actuarial Opinion.”

This opinion shall be filed in accordance with the applicable NAIC Property and Casualty Annual Statement Instructions.

(1) Actuarial Opinion Summary: (A) Every property and casualty insurance company domiciled in this state that is required to submit a Statement of Actuarial Opinion shall annually submit an actuarial opinion summary, written by the company's Appointed Actuary. This actuarial opinion summary shall be filed in accordance with the applicable NAIC Property and Casualty Annual Statement instructions and shall be considered as a document supporting the Actuarial Opinion required in subsection (a) of this section. (B) A company licensed but not domiciled in this state shall provide the actuarial opinion summary upon request.

(2) Actuarial Report and Workpapers: (A) An actuarial report and underlying workpapers as required by the applicable NAIC Property and Casualty Annual Statement Instructions shall be prepared to support each Actuarial Opinion. (B) If the insurance company fails to provide a supporting actuarial report or workpapers at the request of the commissioner or the commissioner determines that the supporting actuarial report or workpapers provided by the insurance company is otherwise unacceptable to the commissioner, the commissioner may engage a Qualified Actuary at the expense of the company to review the opinion and the basis for the opinion and to prepare the supporting actuarial report or workpapers.

(3) The Appointed Actuary shall not be liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision or conduct with respect to the actuary's opinion, except in cases of fraud or willful misconduct on the part of the Appointed Actuary.

(c) For health care centers, the Statement of Actuarial Opinion shall be in the format of and contain the information required by the "Annual Statement Instructions: Health Maintenance Organization" which is published by the National Association of Insurance Commissioners.

(d) Life insurance companies reporting life and/or accident and health premiums shall include as a attachment to page one of its Annual Statement, the Statement of Actuarial Opinion setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts in accordance with the Standard Valuation Law, Sections 38a-77 and 38a-78 of the General Statutes and regulations promulgated thereunder, and to the extent not inconsistent with the foregoing, shall be in the format of and contain the information required by the "Annual Statement Instructions: Life, Accident and Health" which is published by the National Association of Insurance Commissioners.

(Effective September 28, 1993; amended March 4, 2010)

Sec. 38a-53-3. Availability of workpapers and confidentiality

(a) Every insurer required to file a Statement of Actuarial Opinion with its Annual Statement pursuant to this regulation, shall make available all workpapers for review by the Commissioner or his designated representative. Such workpapers shall be maintained at the company and available for examination by the Commissioner or the Commissioner's designated agent from the date of the filing of the Statement of Actuarial Opinion for seven years.

(b) Documents, materials or other information in the possession or control of the Insurance Department, that are furnished to the commissioner pursuant to this section or obtained by the commissioner in a review or examination pursuant to this section, that are considered an actuarial report, workpapers or actuarial opinion summary provided in support of the opinion, and any other material provided by the company to the commissioner in connection with the actuarial report, workpapers or actuarial

opinion summary, shall be kept confidential by the commissioner and shall be confidential by law and privileged. Such information shall not be made public, shall not be subject to subpoena, and shall not be subject to the Freedom of Information Act.

(Effective September 28, 1993; amended March 4, 2010)

Sec. 38a-53-4. Exemptions

(a) Upon written application of an insurer, the Commissioner may issue an exemption from compliance with the provisions of this regulation in the following instances:

(1) An insurer that has less than \$1,000,000 total direct plus assumed written premiums during a calendar year, or that has less than 1,000 policyholders or certificate holders at the end of a calendar year, in lieu of the certification required for the calendar year, may submit an affidavit under oath of an officer of the insurer that specifies that amount of direct, plus assumed, premiums written and the total number of policyholders and certificate holders. An insurer which intends to utilize this exemption shall submit a letter of intent to the insurance regulatory official in its domiciliary state no later than December 1 of the calendar year for which the exemption is to be claimed;

(2) An insurer which is under rehabilitation, liquidation, or any other delinquency proceeding ordered pursuant to a statutory provision unless ordered to make the report by the insurance regulatory official of its domiciliary state;

(3) An insurer writing property insurance only if the exemption is agreed to by the insurance regulatory official in the insurer's domiciliary state based on the nature of the business written;

(4) Filing the report would constitute financial hardship, which is presumed to exist for an insurer other than a health care center if the projected reasonable cost of the report would exceed the lesser of:

(A) One percent of the insurer's capital and surplus reflected in the insurer's annual statement for the calendar year for which the exemption is sought; or

(B) Three percent of the insurer's net direct plus assumed premiums written during the calendar year for which the exemption is sought as reflected in the insurer's annual statement filed with its insurance regulatory official of its domiciliary state.

(Effective September 28, 1993)

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Annual Audited Financial Reports

Sec. 38a-54-1. Purpose and scope

(a) Sections 38a-54-1 to 38a-54-14, inclusive, of the Regulations of Connecticut State Agencies are intended to improve the Insurance Department's surveillance of the financial condition of insurance companies, health care centers and fraternal benefit societies doing business in the State of Connecticut by requiring (1) an annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants, (2) a Communication of Internal Control Related Matters Noted in an Audit, and (3) a Management's Report of Internal Control Over Financial Reporting.

(b)(1) Every insurer as defined in Section 38a-54-2 of the Regulations of Connecticut State Agencies shall be subject to the requirements of Sections 38a-54-1 to 38a-54-14, inclusive, of the Regulations of Connecticut State Agencies. Insurers having direct premiums written in this state of less than \$1,000,000 in any year and having less than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of any year are exempt from Sections 38a-54-1 to 38a-54-14, inclusive, of the Regulations of Connecticut State Agencies for such year, unless the Commissioner makes a specific finding that compliance is necessary for the Commissioner to carry out statutory responsibilities, except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of \$1,000,000 or more shall not be so exempt.

(2) Foreign and alien insurers filing the audited financial reports in another state, pursuant to that state's requirement for filing of audited financial reports which has been found by the Commissioner to be substantially similar to the requirements herein, are exempt from Sections 38a-54-1 to 38a-54-14, inclusive, of the Regulations of Connecticut State Agencies if:

(A) a copy of the audited financial report, Communication of Internal Control Related Matters Noted in an Audit, and the Accountant's Letter of Qualifications, which are filed with such other state, are filed with the Commissioner in accordance with the filing dates specified in Sections 38a-54-3, 38a-54-9a and 38a-54-10, respectively, of the Regulations of Connecticut State Agencies (Canadian insurers may submit accountants' reports as filed with the Office of the Superintendent of Financial Institutions, Canada); and

(B) a copy of any Notification of Adverse Financial Condition Report filed with such other state is filed with the Commissioner within the time specified in Section 38a-54-9 of the Regulations of Connecticut State Agencies.

(C) Foreign or alien insurers required to file a Management's Report of Internal Control Over Financial Reporting in another state are exempt from filing such Report in this state provided the other state has substantially similar reporting requirements and the report is filed with the Commissioner of the other state within the time specified by the other state.

(c) Sections 38a-54-1 to 38a-54-14, inclusive, of the Regulations of Connecticut State Agencies shall not prohibit, preclude or in any way limit the Insurance Commissioner from ordering and/or conducting and/or performing examinations of insurers under the General Statutes, Regulations and procedures of the Connecticut Insurance Department.

(Effective July 29, 1994; amended April 20, 1995, July 23, 2003, December 23, 2008)

Sec. 38a-54-2. Definitions

As used in Sections 38a-54-1 to 38a-54-13, inclusive, of the Regulations of Connecticut State Agencies:

(a) “Accountant” or “independent certified public accountant” means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which he or she is licensed to practice; for Canadian and British companies, it means a Canadian-chartered or British-chartered accountant.

(b) An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(c) “Audit committee” means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers, and audits of financial statements of the insurer or group of insurers. The audit committee of any entity that controls a group of insurers may be deemed to be the audit committee for one or more of these controlled insurers solely for the purposes of Sections 38a-54-1 through 38a-54-14, inclusive, of the Regulations of the Connecticut State Agencies at the election of the controlling person in accordance with the provisions of Section 38a-54-11a(e) of the Regulations of Connecticut State Agencies. If an audit committee is not designated by the insurer, the insurer’s entire board of directors shall constitute the audit committee.

(d) “Audited financial report” or “statutory financial statement” or “audited statutory financial statement” mean and include those items specified in Section 38a-54-4 of the Regulations of Connecticut State Agencies.

(e) “Business combination” means the consolidation, for accounting purposes, of a corporation and one or more incorporated or unincorporated businesses. In a business combination, the multiple entities are considered as one entity for accounting purposes.

(f) “Commissioner” means the Insurance Commissioner of the State of Connecticut.

(g) “Department” or “Insurance Department” means the Insurance Department of the State of Connecticut.

(h) “Indemnification” means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from other misrepresentations made knowingly or otherwise by the insurer or its representatives.

(i) “Independent board member” has the same meaning as described in Section 38a-54-11a of the Regulations of Connecticut State Agencies.

(j) “Insurer” or “Insurance Company” means an insurance company, health care center or fraternal benefit society licensed by the Commissioner to do business in this State.

(k) “Group of insurers” means those licensed insurers included in the reporting requirements of Sections 38a-129 through 38a-142, inclusive, of the Connecticut General Statutes, or a set of such insurers as identified by management, for the purpose of assessing the effectiveness of internal controls over financial reporting.

(l) “Internal control over financial reporting” means a process effected by an entity’s board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of financial statements such as those items specified in Section 38a-54-4 of the Regulations of Connecticut State Agencies and including those policies and procedures that:

(1) Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

(2) Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and

(3) Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material effect on the financial statement.

(m) "NAIC" means the National Association of Insurance Commissioners.

(n) "SEC" means the United States Securities and Exchange Commission.

(o) "Section 404" means Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC's rules and regulations promulgated thereunder.

(p) "Section 404 Report" means a management's report on "internal control over financial reporting" as defined by the SEC and the Communication of Internal Control Related Matters Noted in an Audit.

(q) "SOX compliant entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, the following provisions of the Sarbanes-Oxley Act of 2002: (1) the preapproval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934); (2) the audit committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934); and (3) the internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

(r) "Statutory audit" means the inspection of the accounting records and procedures of a business, government unit, or other reporting entity by an accountant for the purpose of verifying the accuracy and completeness of the records.

(s) "Statutory audit opinion" means the written conclusion based upon the statutory audit which indicates whether in the opinion of the accountant, the admitted assets, liabilities and surplus are represented fairly in all material respects.

(t) "Workpapers" means the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to his or her examination of the financial statements of an insurer. Workpapers, accordingly, may include audit planning documentation, summary of unadjusted differences, audit completion memorandum, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his or her examination of the financial statements of an insurer and which support his or her opinion thereof.

(Effective July 29, 1994; amended April 20, 1995, July 23, 2003, December 23, 2008)

Sec. 38a-54-3. General requirements related to filing and extension for filing of annual audited financial reports and audit committee appointment

(a) All insurers shall have an annual audit by an independent certified public accountant and shall file an audited financial report with the Commissioner on or before June 1 for the year ended December 31 immediately preceding. The Commissioner may require an insurer to file an audited financial report earlier than June 1 with ninety (90) days advance notice to the insurer.

(b) Extensions of the June 1 filing date may be granted by the Commissioner for thirty (30) day periods upon showing by the insurer and its independent certified public accountant the reasons for requesting such extension and determination by the Commissioner of good cause for an extension. The request for extension shall be received in writing not less than ten (10) days prior to the due date in sufficient

detail to permit the Commissioner to make an informed decision with respect to the requested extension.

(c) If an extension is granted in accordance with the provisions of this section, a similar extension of thirty (30) days shall be granted for the filing of the Management's Report of Internal Control Over Financial Reporting.

(d) Each insurer required to file an annual audited financial report pursuant to Sections 38a-54-1 through 38a-54-14, inclusive, of the Regulations of the Connecticut State Agencies shall designate a group of individuals as constituting its audit committee, as defined in Section 38a-54-2 of the Regulations of the Connecticut State Agencies. The audit committee of an entity that controls an insurer may be deemed to be the insurer's audit committee for purposes of Sections 38a-54-1 through 38a-54-14, inclusive, of the Regulations of the Connecticut State Agencies at the election of the controlling person.

(Effective July 29, 1994; amended July 23, 2003, December 23, 2008)

Sec. 38a-54-4. Contents of annual audited financial report

(a) The annual audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the department of insurance of the state of domicile.

(b) The annual audited financial report shall include the following:

- (1) report of independent certified public accountant;
- (2) balance sheet reporting admitted assets, liabilities, capital and surplus;
- (3) statement of operations;
- (4) statement of changes in capital and surplus;
- (5) statement of cash flows;

(6) notes to financial statements. These notes shall be those required by the appropriate NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to Section 38a-53 of the Connecticut General Statutes with a written description of the nature of these differences.

(c) The financial statements included in the Audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the Commissioner; the financial statements shall be comparative, presenting the amounts for the years ended December 31 of the current and immediately preceding year. However, in the first year in which an insurer is required to file an audited financial report, the comparative data may be omitted.

(Effective July 29, 1994; amended April 20, 1995, July 23, 2003, December 23, 2008)

Sec. 38a-54-5. Designation of independent certified public accountant

(a) Each insurer required to file an annual audited financial report pursuant to Section 38a-54-3 of the Regulations of Connecticut State Agencies shall within sixty (60) days after becoming subject to such requirement, register with the Commissioner in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit required by Section 38a-54-3 of the Regulations of Connecticut State Agencies. Insurers not retaining an independent certified public accountant on the effective date of Section 38a-54-3 of the Regulations of Connecticut State Agencies shall register the name and address

of their retained independent certified public accountant not less than six (6) months before the date when the first audited financial report is to be filed.

(b) The insurer shall obtain a letter from the accountant, and file a copy with the Commissioner stating that the accountant is aware of the provisions of the insurance code and the rules and Regulations of the insurance department of its state of domicile that relate to accounting and financial matters and affirming that he or she will express his or her opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by such department, specifying such exceptions as he or she may believe appropriate. If an accountant who was the accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall notify the Connecticut Insurance Department within five (5) business days of this event. The insurer shall also furnish the Commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding such event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, which disagreements, if not resolved to the satisfaction of the former accountant, would have caused him or her to make reference to the subject matter of the disagreement in connection with his or her opinion. The disagreements required to be reported in response to this section include both those resolved to the former accountant's satisfaction and those not resolved to the former independent accountant's satisfaction. Disagreements contemplated by this section are those that occur at the decision-making level, that is, between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer shall also in writing request such former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which he or she does not agree; and the insurer shall furnish such responsive letter from the former accountant to the Commissioner together with its own.

(Effective July 29, 1994; amended April 20, 1995, July 23, 2003, December 23, 2008)

Sec. 38a-54-6. Qualifications of independent certified public accountant

(a) The Commissioner shall not recognize any person or firm as a qualified independent certified public accountant if the person or firm: (1) is not in good standing with the AICPA and in all states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or (2) has either directly or indirectly entered into an agreement of indemnity or release from liability (collectively referred to as "indemnification") with respect to the audit of the insurer.

(b) Except as otherwise provided herein, the Commissioner shall recognize an independent certified public accountant as qualified in accordance with Sections 38a-54-1 to 38a-54-14, inclusive, of the Regulations of Connecticut State Agencies as long as he or she conforms to the standards of his or her profession, as contained in the Code of Professional Ethics of the AICPA and Rules and Regulations and Code of Ethics and Rules of Professional Conduct of the Connecticut State Board of Accountancy, or similar code.

(c) A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under Chapter 704c of the Connecticut General Statutes, the

mediation or arbitration provisions shall operate at the option of the statutory successor.

(d) The lead or coordinating audit partner having primary responsibility for the audit may not act in that capacity for more than five (5) consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of five (5) consecutive years. An insurer may make application to the Commissioner for relief from the above rotation requirement on the basis of unusual circumstances. This application shall be made at least thirty (30) days before the end of the calendar year. The Commissioner may consider the following factors in determining if the relief sought should be granted:

- (1) number of partners, expertise of the partners or the number of insurance clients in the currently registered firm;
- (2) premium volume of the insurer; or
- (3) number of jurisdictions in which the insurer transacts business.

The requirements of this subsection shall become effective on January 1, 2010.

(e) An insurer shall file, with its annual statement filing, the approval for relief as provided in subsection (d) of this section with the states that it is licensed in or doing business in and with the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

(f) The Commissioner shall neither recognize as a qualified independent certified public accountant, nor accept any annual audited financial report prepared in whole or in part by, any person who:

(1) has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Sections 1961- 1968, or any dishonest conduct or practices under federal or state law;

(2) has been found to have violated the insurance laws of this State with respect to any previous reports submitted under Sections 38a-54-1 to 38a-54-14, inclusive, of the Regulations of Connecticut State Agencies; or

(3) has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of Sections 38a-54-1 to 38a-54-14, inclusive, of the Regulations of Connecticut State Agencies.

(g) The Insurance Commissioner may, as provided in Section 38a-16 of the Connecticut General Statutes and the Rules of Practice of the Insurance Department, hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing his or her opinion on the financial statements in the annual audited financial report made pursuant to Section 38a-54-3 of the Regulations of Connecticut State Agencies and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this section.

(h) (1) The Commissioner shall not recognize an independent certified public accountant as qualified, nor accept an annual audited financial report prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following non-audit services:

(A) Bookkeeping or other services related to the accounting records or financial statements of the insurer;

(B) Financial information systems design and implementation;

(C) Appraisal or valuation services, fairness opinions, or contribution-in-kind reports;

(D) Actuarially-oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification on an insurer's reserves if the following conditions have been met:

(i) Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions;

(ii) The insurer has competent personnel, or engages a third party actuary, to estimate the reserves for which management takes responsibility; and

(iii) The accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves;

(E) Internal audit outsourcing services;

(F) Management functions or human resources;

(G) Broker or dealer, investment advisor, or investment banking services;

(H) Legal services or expert services unrelated to the audit; or

(I) Any other services that the Commissioner determines, by regulation, are impermissible.

(2) To be considered independent with respect to services provided by the qualified independent certified public accountant, the accountant shall not function in the role of management, audit his own work, or serve in an advocacy role for the insurer.

(i) Insurers having direct written and assumed premiums of less than \$100,000,000 in any calendar year may request an exemption from subsection (h)(1) of this section. The insurer shall file with the Commissioner a written statement discussing the reasons why the insurer should be exempt from these provisions. If the Commissioner finds, upon review of this statement, that compliance with said subsection would constitute a financial or organizational hardship upon the insurer, an exemption may be granted.

(j) A qualified independent certified public accountant who performs the audit may engage in other non-audit services, including tax services, that are not described in subsection (h)(1) of this section or that do not conflict with subsection (h)(2) of this section, only if the activity is approved in advance by the audit committee, in accordance with subsection (k) of this section.

(k) All auditing services and non-audit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be preapproved by the audit committee. The preapproval requirement is waived with respect to non-audit services if the insurer is a SOX compliant entity or a direct or indirect wholly-owned subsidiary of a SOX compliant entity or:

(1) The aggregate amount of all such non-audit services provided to the insurer constitutes not more than five percent (5%) of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the non-audit services are provided;

(2) The services were not recognized by the insurer at the time of the engagement to be non-audit services; and

(3) The services are promptly brought to the attention of the audit committee and approved prior to the completion of the audit by the audit committee or by one or

more members of the audit committee who are members of the board of directors to whom authority to grant such approvals has been delegated by the audit committee pursuant to subsection (l) of this section.

(l) The audit committee may delegate to one or more designated members of the audit committee who are members of the board of directors the authority to grant pre-approvals required by subsection (k) of this section. The decisions of any members to whom this authority is delegated shall be presented to the full audit committee at each of its scheduled meetings.

(m) (1) The Commissioner shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, comptroller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer, was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory audit opinion is due. This subsection shall only apply to partners and senior managers involved in the audit. An insurer may make written application to the Commissioner for relief from this subsection on the basis of unusual circumstances.

(2) The insurer shall file, with its annual statement filing, the approval for relief from subsection (m)(1) of this section with the states that it is licensed in or doing business in and the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

(n) The requirements of subsections (h) through (m), inclusive, of this section shall be effective for audits in the year beginning January 1, 2010.

(Effective July 29, 1994; amended April 20, 1995, July 23, 2003, December 23, 2008, September 2, 2009)

Sec. 38a-54-7. Consolidated or combined audits

An insurance company may make written application to the Commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies which utilizes a pooling or one hundred percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and such insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet shall be filed with the report, as follows:

(1) Amounts shown on the consolidated or combined audited financial report shall be shown on the worksheet.

(2) Amount for each insurer subject to this section shall be stated separately.

(3) Noninsurance operations may be shown on the worksheet on a combined or individual basis.

(4) Explanations of consolidating and eliminating entries shall be included.

(5) A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statements of the insurers.

(Effective July 29, 1994; amended July 23, 2003, December 23, 2008)

Sec. 38a-54-8. Scope of audit and report of independent certified public accountant

Financial statements furnished pursuant to Section 38a-54-4 of the Regulations of Connecticut State Agencies shall be examined by the independent certified public accountant. The audit of the insurance company's financial statements shall be

conducted in accordance with generally accepted auditing standards. In accordance with AU Section 319 of the Professional Standards of the AICPA, Consideration of Internal Control in a Financial Statement Audit, the independent certified public accountant shall obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU 319, for those insurers required to file a Management's Report of Internal Control Over Financial Reporting pursuant to Section 38a-54-11c of the Regulations of Connecticut State Agencies, the independent certified public accountant shall consider, as that term is defined in Statement on Auditing Standards 102, Defining Professional Requirements in Statements on Auditing Standards or its replacement, the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the procedures illustrated in the Financial Condition Examiner's Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

(Effective July 29, 1994; amended July 23, 2003, December 23, 2008)

Sec. 38a-54-9. Notification of adverse financial condition

(a) The insurer required to furnish the annual audited financial report shall require the independent certified public accountant to notify in writing within five (5) business days the board of directors or its audit committee any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the Commissioner as of the balance sheet date currently under audit or that the insurer does not meet the minimum capital and surplus requirement of Section 38a-72 of the Connecticut General Statutes, as amended, as of that date. The insurer shall furnish such notification to the Commissioner within five (5) business days of receipt thereof and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the Commissioner. If the independent certified public accountant fails to receive such evidence within the required five (5) business day period, the independent certified public accountant shall furnish to the Commissioner a copy of its report within the next five (5) business days.

(b) No independent certified public accountant shall be liable in any manner to any person for any statement made in connection with this section if such statement is made in good faith compliance with this section.

(c) If the accountant, subsequent to the date of the audited financial report filed pursuant to Section 38a-54-3 of the Regulations of Connecticut State Agencies, becomes aware of facts which might have affected his or her report, the accountant shall fulfill his or her obligation to take such action as prescribed in Volume 1, Section AU 561 of the Professional Standards of the AICPA.

(Effective July 29, 1994; amended April 20, 1995, July 23, 2003, December 23, 2008)

Sec. 38a-54-9a. Communication of internal control related matters noted in an audit

(a) In addition to the annual audited financial report, each insurer shall furnish the Commissioner with a written communication as to any unremediated material weaknesses in its internal controls over financial reporting noted during the audit. Such communication shall be prepared by the accountant within sixty (60) days after the filing of the annual audited financial report, and shall contain: a description of any unremediated material weakness, as the term "material weakness" is defined in Statement on Auditing Standards 60, Communication of Internal Control Related Matters Noted in an Audit, or its replacement as of December 31 immediately

preceding, so as to coincide with the audited financial report set forth in Section 38a-54-3 of the Regulations of the Connecticut State Agencies in the insurer's internal control over financial reporting noted by the accountant during the course of the audit.

(b) The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions are not described in the accountant's communications.

(c) If no unremediated material weaknesses were noted, the communication should so state in written notification to the Commissioner by June 1 as part of the annual audited financial report filing.

(Effective July 29, 1994; amended April 20, 1995, July 23, 2003, December 23, 2008)

Sec. 38a-54-10. Accountant's letter of qualifications

The accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual audited financial report, a letter which states all of the following:

(1) That the accountant is independent with respect to the insurer and conforms to the standards or his or her profession as contained in the Code of Professional Ethics and pronouncements of the AICPA and the Rules of Professional Conduct of the Connecticut State Board of Accountancy, or similar code.

(2) With respect to the staff assigned to the engagement, their background and experience in general, their experience in audits of insurers, and whether each is an independent certified public accountant. Nothing within Sections 38a-54-1 to 38a-54-14, inclusive, of the Regulations of Connecticut State Agencies shall be construed as prohibiting the accountant from utilizing such staff as he or she deems appropriate where use is consistent with the standards prescribed by generally accepted auditing standards.

(3) That the accountant understands the annual audited financial report and his or her opinion thereon will be filed in compliance with Sections 38a-54-1 to 38a-54-14, inclusive, of the Regulations of Connecticut State Agencies and that the Commissioner will be relying on this information in the monitoring and regulation of the financial position of insurers.

(4) That the accountant consents to the requirements of Section 38a-54-11 of the Regulations of Connecticut State Agencies and that the accountant consents and agrees to make available for review by the Commissioner, his designee or his appointed agent, the workpapers, as defined in Section 38a-54-2 of the Regulations of Connecticut State Agencies.

(5) A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the AICPA.

(6) A representation that the accountant is in compliance with the requirements of Section 38a-54-6 of the Regulations of Connecticut State Agencies.

(Effective July 29, 1994; amended April 20, 1995, July 23, 2003, December 23, 2008)

Sec. 38a-54-11. Availability and maintenance of independent CPA workpapers

(a) Every insurer required to file an audited financial report pursuant to Section 38a-54-3 of the Regulations of Connecticut State Agencies, shall require the accountant to make available for review by Insurance Department examiners, all workpapers prepared in the conduct of his or her audit and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the Insurance Department or at any other reasonable place designated by the Commis-

sioner. The insurer shall require that the accountant retain the audit workpapers and communications until the Insurance Department has filed a report of examination covering the period of the audit but no longer than seven (7) years from the date of the audit report.

(b) In the conduct of the aforementioned periodic review by the Department examiners, it shall be agreed that photocopies of pertinent audit workpapers may be made and retained by the Department. Such reviews by the Department examiners shall be considered investigations and all working papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination workpapers generated by the Department.

(Effective July 29, 1994; amended April 20, 1995, July 23, 2003, December 23, 2008)

Sec. 38a-54-11a. Requirements for audit committees

(a) This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX compliant entity or a direct or indirect wholly-owned subsidiary of a SOX compliant entity.

(b) The audit committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant (including resolution of disagreements between management and the accountant regarding financial reporting) for the purpose of preparing or issuing the audited financial report or related work pursuant to this section. Each accountant shall report directly to the audit committee.

(c) Each member of the audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to subsection (e) of this section and Section 38a-54-2(c) of the Regulations of Connecticut State Agencies.

(d) In order to be considered independent for purposes of this section, a member of the audit committee may not, other than in his or her capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof. However, if law requires board participation by otherwise non-independent members, that law shall prevail and such members may participate in the audit committee and be designated as independent for audit committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

(e) If a member of the audit committee ceases to be independent for reasons outside the member's reasonable control, such member, with notice by the responsible entity to the Commissioner, may remain an audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

(f) To exercise the election of the controlling person to designate the audit committee for purposes of this section, the ultimate controlling person shall provide written notice to the commissioners of the states in which the affected insurers are licensed in or do business in. Timely notification shall be made prior to the issuance of the report of the statutory audit opinion and include a description of the basis for the election. The election may be changed through notice to the Commissioner by the insurer, which shall include a description of the basis for the change. The election shall remain in effect, until rescinded.

(g)(1) The audit committee shall require the accountant that performs for an insurer any audit required by this section to timely report to the audit committee in accordance with the requirements of Statement on Auditing Standards 61, Communication with Audit Committees, or its replacement, including:

- (A) all significant accounting policies and material permitted practices;
- (B) all material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and

(C) other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

(2) If an insurer is a member of an insurance holding company system, the reports required by subdivision (1) of this subsection may be provided to the audit committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the audit committee.

(h) The proportion of independent audit committee members shall meet or exceed the following criteria;

Prior Calendar Year Direct Written and Assumed Premiums		
\$0 - \$300,000,000	Over \$300,000,000 - \$500,000,000	Over \$500,000,000
No minimum requirements. See also Note A, B and C.	Majority (50% or more) of members shall be independent. See also Note A, B and C.	Supermajority of members (75% or more) shall be independent. See also Note A and C.

Note A: As provided in Sections 38a-8 and 38a-72 of the Connecticut General Statutes, the Commissioner shall require the entity’s board to enact improvements to the independence of the audit committee membership if the insurer is in a risk-based capital action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.

Note B: All insurers with less than \$500,000,000 in prior year direct written and assumed premiums are encouraged to structure their audit committees with at least a supermajority of independent audit committee members.

Note C: Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities.

(i) An insurer with direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than \$500,000,000 may make written application to the Commissioner for a waiver from the requirements of this section based upon hardship. The insurer shall file, with its annual statement filing, any approval for relief granted by the Commissioner from this section with the states that it is licensed in or doing business in and the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

(j) The requirements of this section shall be effective January 1, 2010. An insurer or group of insurers that is not required to have independent audit committee members or only a majority of independent audit committee members, as opposed to a supermajority, because the total written and assumed premium is below the threshold that subsequently becomes subject to one of the independence requirements as provided in Section 38a-54-11a(h) of the Regulations of Connecticut State Agen-

cies due to changes in premium shall have one year following the year the threshold is exceeded, but not earlier than January 1, 2010, to comply with the independence requirements. Likewise, an insurer that becomes subject to one of the independence requirements as a result of a business combination shall have one calendar year following the date of acquisition or business combination to comply with the independence requirements.

(Adopted effective December 23, 2008)

Sec. 38a-54-11b. Conduct of insurer in connection with the preparation of required reports and documents

(a) No director or officer of an insurer shall, directly or indirectly: (1) Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under this section; or (2) make, or cause another person to make, a misleading statement by omitting a material statement to an accountant in connection with any audit, review or communication required under this section.

(b) No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to Sections 38a-54-1 through 38a-54-14, inclusive, of the Regulations of the Connecticut State Agencies if such director, officer or person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

(c) For purposes of subsection (b) of this section, actions that if successful, could result in rendering the insurer's financial statements materially misleading include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant:

(1) To issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances (due to material violations of statutory accounting principles prescribed by the Commissioner, generally accepted auditing standards, or other professional or regulatory standards);

(2) Not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards;

(3) Not to withdraw an issued report; or

(4) Not to communicate matters to an insurer's audit committee.

(d) The requirements of this section shall be effective beginning with the reporting period ending December 31, 2010 and each year thereafter. An insurer or group of insurers that is not required to file a report because the total written premium is below the threshold that subsequently becomes subject to the reporting requirements shall have two years following the year the threshold is exceeded, but not earlier than December 31, 2010 to file a report. Likewise, an insurer acquired in a business combination shall have two calendar years following the date of acquisition or business combination to comply with the reporting requirements.

(Adopted effective December 23, 2008)

Sec. 38a-54-11c. Management's report of internal control over financial reporting

(a) Each insurer required to file an audited financial report pursuant to Sections 38a-54-1 through 38a-54-14, inclusive, of the Regulations of the Connecticut State Agencies that has annual direct written and assumed premiums, excluding premiums

reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of \$500,000,000 or more shall prepare a report of the insurer's or group of insurers' internal control over financial reporting, as these terms are defined in Section 38a-54-2. The report shall be filed with the Commissioner along with the Communication of Internal Control Related Matters Noted in an Audit described under Section 38a-54-9a of the Regulations of Connecticut State Agencies. The Management's Report of Internal Control Over Financial Reporting shall be as of December 31 immediately preceding.

(b) Notwithstanding the premium threshold in subsection (a) of this section, the Commissioner may require an insurer to file a Management's Report of Internal Control over Financial Reporting if the insurer is in a risk-based capital level event, or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in Sections 38a-8-101 to 38a-104, inclusive, 38a-72-1 to 38a-72-13, inclusive, and 38a-193-1 to 38a-193-13, inclusive, of the Regulations of the Connecticut State Agencies.

(c) An insurer or a group of insurers that is (1) directly subject to Section 404; (2) part of a holding company system whose parent is directly subject to Section 404; (3) not directly subject to Section 404 but is a SOX compliant entity; or (4) a member of a holding company system whose parent is not directly subject to Section 404 but is a SOX compliant entity, may file its or its parent's Section 404 Report and an addendum in satisfaction of this section's requirement, provided that the internal controls of the insurer or group of insurers having a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in Section 38a-54-4 of the Regulations of Connecticut State Agencies) were included in the scope of Section 404 Reports. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in Section 38a-54-4 of the Regulations of Connecticut State Agencies) excluded from the Section 404 Report. If there are internal controls of the insurer or group of insurers or that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 Report, the insurer or group of insurers may either file a report pursuant to this section or a Section 404 Report and a report pursuant to this section for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the Section 404 Report.

(d) The Management's Report of Internal Control Over Financial Reporting shall include:

(1) A statement that management is responsible for establishing and maintaining adequate internal controls over financial reporting;

(2) A statement that management has established internal controls over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal controls over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

(3) A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal controls over financial reporting;

(4) A statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

(5) Disclosure of any unremediated material weaknesses in the internal controls over financial reporting identified by management as of December 31 immediately preceding. Management shall not conclude that the internal controls over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one or more unremediated material weaknesses in its Internal controls over financial reporting;

(6) A statement regarding the inherent limitations of internal control systems; and

(7) Signatures of the chief executive officer and the chief financial officer or equivalent position or title.

(e)(1) Management shall document and make available upon financial condition examination the basis upon which its assertions, required in subsection (d) of this section are made. Management may base its assertions, in part, upon its review, monitoring and testing of internal controls undertaken in the normal course of its activities.

(2) Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost effective manner, and as such, may include assembly of or reference to existing documentation.

(3) Management's Report on Internal Control Over Financial Reporting, required by subsection (a) of this section, and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the insurance department.

(f) The requirements of this section shall be effective beginning with the reporting period ending December 31, 2010 and each year thereafter. An insurer or group of insurers that is not required to file a report because the total written premium is below the threshold that subsequently becomes subject to the reporting requirements shall have two years following the year the threshold is exceeded, but not earlier than December 31, 2010 to file a report. Likewise, an insurer acquired in a business combination shall have two calendar years following the date of acquisition or business combination to comply with the reporting requirements.

(Adopted effective December 23, 2008)

Sec. 38a-54-12. Exemptions and compliance dates

(a) Upon written application of any insurer, the Commissioner may grant an exemption from compliance with Sections 38a-54-1 to 38a-54-14, inclusive, of the Regulations of Connecticut State Agencies if the Commissioner finds, upon review of the application, that compliance would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten (10) days from a denial of an insurer's written request for an exemption, such insurer may request in writing a hearing on its application for an exemption. Such hearing shall be held in accordance with the rules of practice of the Insurance Department, Sections 38a-8-7 to 38a-8-75, inclusive, of the Regulations of Connecticut State Agencies. A request for exemption must be made for each calendar year for which such exemption is sought. Application for exemption must be received on or before December 31 of the year for which such exemption is sought.

(b) Domestic insurers retaining a certified public accountant on the effective date of Sections 38a-54-1 to 38a-54-14, inclusive, who qualify as independent in accordance with AICPA standards, shall comply with Sections 38a-54-1 to 38a-54-14, inclusive, of the Regulations of Connecticut State Agencies for the year ending

December 31, 2008 and each year thereafter unless the Commissioner permits otherwise.

(c) Domestic insurers not retaining a certified public accountant on the effective date of Sections 38a-54-1 to 38a-54-14, inclusive, of the Regulations of Connecticut State Agencies who qualifies as independent in accordance with AICPA standards, shall meet the following schedule for compliance unless the Commissioner permits otherwise:

(1) As of December 31, 2008, file with the Commissioner an audited financial report;

(2) For the year ending December 31, 2008, and each year thereafter, file with the Commissioner all reports and communication required by Sections 38a-54-1 to 38a-54-14, inclusive, of the Regulations of Connecticut State Agencies.

(d) Foreign insurers shall comply with Sections 38a-54-1 to 38a-54-14, inclusive, of the Regulations of Connecticut State Agencies for the year ending December 31, 2008 and each year thereafter, unless the Commissioner permits otherwise.

(Effective July 29, 1994; amended July 23, 2003, December 23, 2008)

Sec. 38a-54-13. Canadian and British companies

(a) In the case of Canadian and British insurers, the annual audited financial report shall be defined as the annual statement of total business on the form filed by such companies with their supervision authority duly audited by an independent chartered accountant.

(b) For such insurers, the letter required in Section 38a-54-5 of the Regulations of Connecticut State Agencies shall state that the accountant is aware of the requirements relating to the annual audited financial report filed with the Commissioner pursuant to Section 38a-54-3 and shall affirm that the opinion expressed is in conformity with such requirements.

(Effective July 29, 1994; amended July 23, 2003, December 23, 2008)

Sec. 38a-54-14. Severability

If any provision of Sections 38a-54-1 to 38a-54-13, inclusive, of the Regulations of Connecticut State Agencies or the applicability thereof to any person or circumstance is held to be invalid, the remainder of said sections or the applicability of such provision to other persons or circumstances shall not be affected thereby.

(Effective July 29, 1994; amended July 23, 2003, December 23, 2008)

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Risk Based Capital For Insurers

Sec. 38a-72-1. Definitions

As used in sections 38a-72-1 to 38a-72-13, inclusive, of the Regulations of Connecticut State Agencies:

(a) “Adjusted RBC Report” means an RBC Report which has been adjusted by the commissioner in accordance with section 38a-72-2(e) of the Regulations of Connecticut State Agencies;

(b) “Commissioner” means the Insurance Commissioner of the State of Connecticut;

(c) “Corrective Order” means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required;

(d) “Domestic insurer” means any insurance company domiciled in Connecticut;

(e) “Foreign insurer” means any insurance company that is licensed to do business in Connecticut under section 38a-41(a) of the Connecticut General Statutes but is not domiciled in Connecticut;

(f) “NAIC” means the National Association of Insurance Commissioners;

(g) “Life and/or health insurer” means any insurance company licensed under section 38a-41 of the Connecticut General Statutes, or a licensed property and casualty insurer writing only accident and health insurance;

(h) “Property and casualty insurer” means any insurance company licensed under section 38a-41 of the Connecticut General Statutes but shall not include monoline mortgage guaranty insurers, financial guaranty insurers and title insurers;

(i) “Negative Trend” means, with respect to a life and/or health insurer, a negative trend over a period of time, as determined in accordance with the “Trend Test Calculation” included in the Life RBC Instructions;

(j) “RBC” means risk based capital;

(k) “RBC Instructions” means the RBC Report including risk-based capital instructions adopted by the NAIC, as such RBC Instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC;

(l) “RBC Level” means an insurer’s Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC where:

(1) “Company Action Level RBC” means, with respect to any insurer, the product of 2.0 and its Authorized Control Level RBC;

(2) “Regulatory Action Level RBC” means the product of 1.5 and its Authorized Control Level RBC;

(3) “Authorized Control Level RBC” means the number determined under the risk-based capital formula in accordance with the RBC Instructions; and

(4) “Mandatory Control Level RBC” means the product of .70 and the Authorized Control Level RBC;

(m) “RBC Plan” means a comprehensive financial plan containing the elements specified in section 38a-72-3(b) of the Regulations of Connecticut State Agencies. If the commissioner rejects the RBC Plan, and it is revised by the insurer, with or without the commissioner’s recommendation, the plan shall be called the “Revised RBC Plan”;

(n) “RBC Report” means the report required in section 38a-72-2 of the Regulations of Connecticut State Agencies; and

(o) “Total Adjusted Capital” means the sum of: an insurer’s statutory capital and surplus; and such other items, if any, as the RBC Instructions may provide.

(Effective September 28, 1994; amended November 30, 2006)

Sec. 38a-72-2. RBC reports

(a) Every domestic insurer shall, on or prior to each March 1 (the “filing date”), prepare and submit to the commissioner a report of its RBC Levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC Instructions. In addition, every domestic insurer shall file its RBC Report:

(1) With the NAIC in accordance with the RBC Instructions; and

(2) With the insurance commissioner in any state in which the insurer is authorized to do business, if the insurance commissioner has notified the insurer of its request in writing, in which case the insurer shall file its RBC Report not later than the later of: fifteen (15) days from the receipt of notice to file its RBC Report with that state; or the filing date.

(b) A life and/or health insurer’s RBC shall be determined in accordance with the formula set forth in the RBC Instructions. The formula shall take into account (and may adjust for the covariance between):

(1) The risk with respect to the insurer’s assets;

(2) The risk of adverse insurance experience with respect to the insurer’s liabilities and obligations;

(3) The interest rate risk with respect to the insurer’s business; and

(4) All other business risks and such other relevant risks as are set forth in the RBC instructions; determined in each case by applying the factors in the manner set forth in the RBC Instructions.

(c) A property and casualty insurer’s RBC shall be determined in accordance with the formula set forth in the RBC Instructions. The formula shall take into account (and may adjust for the covariance between):

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

(4) All other risks and such other relevant risks as are set forth in the RBC Instructions; determined in each case by applying the factors in the manner set forth in the RBC Instructions.

(d) An excess of capital over the amount produced by the risk-based capital requirements contained in sections 38a-72-1 to 38a-72-13, inclusive, and the formulas, schedules and instructions referenced in said sections is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by sections 38a-72-1 to 38a-72-13, inclusive. Additional capital is used and is useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in sections 38a-72-1 to 38a-72-13, inclusive.

(e) If a domestic insurer files an RBC Report which in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBC Report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC Report as so adjusted is referred to as an “Adjusted RBC Report.”

(Effective September 29, 1994)

Sec. 38a-72-3. Company action level event

(a) “Company Action Level Event” means any of the following events:

(1) The filing of an RBC Report by an insurer which indicates that:

(A) The insurer's Total Adjusted Capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC;

(B) If a life and/or health insurer, the insurer has Total Adjusted Capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 2.5 and has a Negative Trend; or

(C) If a property and casualty insurer, the insurer has Total Adjusted Capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and triggers the trend test determined in accordance with the "Trend Test Calculation" included in the Property and Casualty RBC instructions;

(2) The notification by the commissioner to the insurer of an Adjusted RBC Report that indicates the event in subdivision (1) of this subsection, provided the insurer does not challenge the Adjusted RBC Report under section 38a-72-7 of the Regulations of Connecticut State Agencies; or

(3) If, pursuant to section 38a-72-7 of the Regulations of Connecticut State Agencies, an insurer challenges an Adjusted RBC Report that indicates the event in subdivision (1) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a Company Action Level Event, the insurer shall prepare and submit to the commissioner an RBC Plan which shall:

(1) Identify the conditions that contribute to the Company Action Level Event;

(2) Contain proposals of corrective actions that the insurer intends to take and would be expected to result in the elimination of the Company Action Level Event;

(3) Provide projections of the insurer's financial results in the current year and at least the four (4) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and/or surplus. (The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component);

(4) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(5) Identify the quality of, and problems associated with, the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(c) The RBC Plan shall be submitted within forty-five (45) days of the Company Action Level Event; or if the insurer challenges an Adjusted RBC Report pursuant to section 38a-72-7 of the Regulations of Connecticut State Agencies, within forty-five (45) days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(d) Within sixty (60) days after the submission by an insurer of an RBC Plan to the commissioner, the commissioner shall notify the insurer whether the RBC plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines that the RBC Plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions that will render the RBC Plan satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the insurer shall prepare a Revised RBC Plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the Revised RBC Plan to the commissioner

within forty-five (45) days after the notification from the commissioner; or if the insurer challenges an Adjusted RBC Report pursuant to section 38a-72-7 of the Regulations of Connecticut State Agencies, within forty-five (45) days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(e) In the event of a notification by the commissioner to an insurer that the insurer's RBC Plan or Revised RBC Plan is unsatisfactory, the commissioner may at the commissioner's discretion, subject to the insurer's right to a hearing under section 38a-72-7 of the Regulations of Connecticut State Agencies, specify in the notification that the notification constitutes a Regulatory Action Level Event.

(f) Every domestic insurer that files an RBC Plan or Revised RBC Plan with the commissioner shall file a copy of the RBC Plan or Revised RBC Plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(1) Such state has an RBC provision substantially similar to section 38a-72-8(a) of the Regulations of Connecticut State Agencies; and

(2) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC Plan or Revised RBC Plan in that state no later than the later of:

(A) Fifteen (15) days after the receipt of notice to file a copy of its RBC Plan or Revised Plan with the state; or

(B) The date on which the RBC Plan or Revised RBC Plan is filed under subsections (c) and (d) of section 38a-72-3 of the Regulations of Connecticut State Agencies.

(Effective September 28, 1994; amended November 30, 2006)

Sec. 38a-72-4. Regulatory action level event

(a) "Regulatory Action Level Event" means, with respect to any insurer, any of the following events:

(1) The filing of an RBC Report by the insurer which indicates that the insurer's Total Adjusted Capital is greater than or equal to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;

(2) The notification by the commissioner to an insurer of an Adjusted RBC Report that indicates the event in subdivision (1) of this subsection, provided the insurer does not challenge the Adjusted RBC Report under section 38a-72-7;

(3) If, pursuant to section 38a-72-7, the insurer challenges an Adjusted RBC Report that indicates the event in subdivision (1) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge;

(4) The failure of the insurer to file an RBC Report by the filing date, unless the insurer has provided an explanation for such failure which is satisfactory to the commissioner and has cured the failure within ten (10) days after the filing date;

(5) The failure of the insurer to submit an RBC Plan to the commissioner within the time period set forth in Section 38a-72-3 (c);

(6) Notification by the commissioner to the insurer that the RBC Plan or Revised RBC Plan submitted by the insurer is, in the judgment of the commissioner, unsatisfactory, and such notification constitutes a Regulatory Action Level Event with respect to the insurer, provided the insurer has not challenged the determination under section 38a-72-7;

(7) If, pursuant to section 38a-72-7, the insurer challenges a determination by the commissioner under subdivision (6) of this subsection, the notification by the

commissioner to the insurer that the commissioner has, after a hearing, rejected such challenge;

(8) Notification by the commissioner to the insurer that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan, but only if such failure has a substantial adverse effect on the ability of the insurer to eliminate the Regulatory Action Level Event in accordance with its RBC Plan or Revised RBC Plan and the commissioner has so stated in the notification, provided the insurer has not challenged the determination under Section 38a-72-7; or

(9) If, pursuant to section 38a-72-7, the insurer challenges a determination by the commissioner under subdivision (8) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the challenge.

(b) In the event of a Regulatory Action Level Event the commissioner shall:

(1) Require the insurer to prepare and submit an RBC Plan or, if applicable, a Revised RBC Plan;

(2) Perform such examination or analysis as the commissioner deems necessary of the assets, liabilities and operations of the insurer including a review of its RBC Plan or Revised RBC Plan; and

(3) Subsequent to the examination or analysis, issue an order specifying such corrective actions as the commissioner shall determine are required (a "Corrective Order").

(c) In determining corrective actions, the commissioner may take into account such factors as are deemed relevant with respect to the insurer based upon the commissioner's examination or analysis of the assets, liabilities and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC Instructions. The RBC Plan or Revised RBC Plan shall be submitted:

(1) Within forty-five (45) days after the occurrence of the Regulatory Action Level Event;

(2) If the insurer challenges an Adjusted RBC Report pursuant to section 38a-72-7 and the challenge is not frivolous in the judgment of the commissioner, within forty-five (45) days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge; or

(3) If the insurer challenges a Revised RBC Plan under section 38a-72-7 and the challenge is not frivolous in the judgment of the commissioner, within forty-five (45) days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(d) The commissioner may retain actuaries and investment experts and other consultants as necessary in the judgment of the commissioner to review the insurer's RBC Plan or Revised RBC Plan, examine or analyze the assets, liabilities and operations of the insurer and formulate the Corrective Order with respect to the insurer. The fees, costs and expenses relating to consultants shall be borne by the affected insurer or such other party as directed by the commissioner.

(Effective September 28, 1994)

Sec. 38a-72-5. Authorized control level event

(a) "Authorized Control Level Event" means any of the following events:

(1) The filing of an RBC Report by the insurer which indicates that the insurer's Total Adjusted Capital is greater than or equal to its Mandatory Control Level RBC but less than its Authorized Control Level RBC;

(2) The notification by the commissioner to the insurer of an Adjusted RBC Report that indicates the event in subdivision (1) of this subsection, provided the insurer does not challenge the Adjusted RBC Report under Section 38a-72-7;

(3) If, pursuant to section 38a-72-7, the insurer challenges an Adjusted RBC Report that indicates the event in subdivision (1) of this subsection, notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge;

(4) The failure of the insurer to respond, in a manner satisfactory to the commissioner, to a Corrective Order under section 38a-72-7; or

(5) If the insurer has challenged a Corrective Order under section 38a-72-7 and the commissioner has, after a hearing, rejected the challenge or modified the Corrective Order, the failure of the insurer to respond, in a manner satisfactory to the commissioner, to the Corrective Order subsequent to rejection or modification by the commissioner.

(b) In the event of an Authorized Control Level Event with respect to an insurer, the commissioner shall:

(1) Take such actions as are required under section 38a-72-4 regarding an insurer with respect to which a Regulatory Action Level Event has occurred; or

(2) If the commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take such actions as are necessary to cause the insurer to be placed under regulatory control under Chapter 704c of the General Statutes. In the event the commissioner takes such actions, the Authorized Control Level Event shall be deemed sufficient grounds for the commissioner to take action under Chapter 704c of the General Statutes, and the commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in Chapter 704c of the General Statutes. In the event the commissioner takes actions under this subsection pursuant to an Adjusted RBC Report, the insurer shall be entitled to such protections as are afforded to insurers under the provisions of Chapter 704c, pertaining to summary proceedings.

(Effective September 28, 1994)

Sec. 38a-72-6. Mandatory control level event

(a) "Mandatory Control Level Event" means any of the following events:

(1) The filing of an RBC Report which indicates that the insurer's Total Adjusted Capital is less than its Mandatory Control Level RBC;

(2) Notification by the commissioner to the insurer of an Adjusted RBC Report that indicates the event in subdivision (1) of this subsection, provided the insurer does not challenge the Adjusted RBC Report under section 38a-72-7; or

(3) If, pursuant to section 38a-72-7, the insurer challenges an Adjusted RBC Report that indicates the event in subdivision (1) of this subsection, notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a Mandatory Control Level Event:

(1) With respect to a life and/or health insurer, the commissioner shall take actions as are necessary to place the insurer under regulatory control under Chapter 704c of the General Statutes. In that event, the Mandatory Control Level Event shall be deemed sufficient grounds for the commissioner to take action under Chapter 704c of the General Statutes, and the commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in Chapter 704c of the General Statutes. In the event the commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to the protections of the provisions of Chapter

704c of the General Statutes pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety (90) days after the Mandatory Control Level Event if the commissioner finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety (90) day period.

(2) With respect to a property and casualty insurer, the commissioner shall take such actions as are necessary to place the insurer under regulatory control under Chapter 704c of the General Statutes, or, in the case of an insurer which is writing no business and which is running-off its existing business, may allow the insurer to continue its run-off under the supervision of the commissioner. In either event, the Mandatory Control Event shall be deemed sufficient grounds for the commissioner to take action under Chapter 704c of the General Statutes and the commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in Chapter 704c of the General Statutes. If the commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to the protections of the provisions of Chapter 704c of the General Statutes pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety (90) days after the Mandatory Control Level Event if the commissioner finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety (90) day period.

(Effective September 28, 1994)

Sec. 38a-72-7. Hearings

(a) The insurer shall have the right to a departmental hearing, on a record, at which the insurer may challenge any determination or action by the commissioner upon:

(1) Notification to an insurer by the commissioner of an Adjusted RBC Report; or

(2) Notification to an insurer by the commissioner that the insurer's RBC Plan or Revised RBC Plan is unsatisfactory, and such notification constitutes a Regulatory Action Level Event with respect to such insurer; or

(3) Notification to any insurer by the commissioner that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan and that such failure has a substantial adverse effect on the ability of the insurer to eliminate the Company Action Level Event with respect to the insurer in accordance with its RBC Plan or Revised RBC Plan; or

(4) Notification to an insurer by the commissioner of a Corrective Order with respect to the insurer.

(b) The insurer shall notify the commissioner of its request for a hearing within five (5) days after the notification by the commissioner under subdivisions (1), (2), (3), or (4) of subsection (a) of this section. Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing, which date shall be no less than ten (10) days nor more than thirty (30) days after the date of the insurer's request.

(Effective September 28, 1994)

Sec. 38a-72-8. Confidentiality and prohibition on announcements

(a) All RBC Reports (to the extent the information therein is not required to be set forth in a publicly available annual statement schedule) and RBC Plans (including the results or report of any examination or analysis of an insurer performed pursuant hereto and any Corrective Order issued by the commissioner pursuant to examination or analysis) with respect to any domestic insurer or foreign insurer which are filed with the commissioner constitute information that might be damaging to the insurer

if made available to its competitors, and therefore shall be kept confidential by the commissioner, pursuant to the authority of sections 38a-14, 38a-69a, 38a-913 and 38a-962c of the General Statutes. This information shall not be made public and/or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to the provisions of sections 38a-72-1 to 38a-72-13, inclusive, or any other provision of the insurance laws or regulations of this state.

(b) The comparison of an insurer's Total Adjusted Capital to any of its RBC levels is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer, and is not intended as a means to rank insurers generally. Therefore, except as otherwise required under the provisions of sections 38a-72-1 to 38a-72-13, inclusive, the making, publishing, disseminating, circulating or placing before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC Levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the comparison regarding an insurer's Total Adjusted Capital to its RBC Levels (or any of them) or an inappropriate comparison of any other amount to the insurers' RBC Levels is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(c) The RBC Instructions, RBC Reports, Adjusted RBC Reports, RBC Plans and Revised RBC Plans are intended solely for use by the commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate for any line of insurer which an insurer or any affiliate is authorized to write.

(Effective September 28, 1994)

Sec. 38a-72-9. Supplemental provisions; Exemption

(a) The provisions of sections 38a-72-1 to 38a-72-13, inclusive, are supplemental to any other provisions of the laws and regulations of this state, and shall not preclude or limit any other powers or duties of the commissioner under such laws or regulations, including, but not limited to, Chapter 704c of the General Statutes and sections 38a-8-101 to 38a-8-104, inclusive.

(b) The commissioner may exempt from the application of sections 38a-72-1 to 38a-72-13, inclusive, any domestic property and casualty insurer which: (1) writes direct business only in this state; (2) writes direct annual premiums of two million dollars (\$2,000,000) or less; and (3) assumes no reinsurance in excess of five percent (5%) of direct premium written.

(Effective September 28, 1994)

Sec. 38a-72-10. Foreign insurers

(a) Any foreign insurer shall, upon the written request of the commissioner, submit to the commissioner an RBC Report as of the end of the calendar year just ended the later of:

(1) The date an RBC Report would be required to be filed by a domestic insurer under the provisions of sections 38a-72-1 to 38a-72-13, inclusive; or

(2) Fifteen (15) days after the request is received by the foreign insurer.

Any foreign insurer shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC Plan that is filed with the insurance commissioner of any other state.

(b) In the event of a Company Action Level Event or Regulatory Action Level Event with respect to any foreign insurer as determined under the RBC statute applicable in the state of domicile of the insurer (or, if no RBC provision is in force in that state, under the provisions of sections 38a-72-1 to 38a-72-13, inclusive), if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file an RBC Plan in the manner specified under the RBC statute (or, if no RBC provision is in force in the state, under section 38a-72-3), the commissioner may require the foreign insurer to file an RBC Plan with the commissioner. In such event, the failure of the foreign insurer to file an RBC Plan with the commissioner shall be grounds to order the insurer to cease and desist from writing new insurance business in this state.

(c) In the event of a Mandatory Control Level Event with respect to any foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the commissioner may make application to the Superior Court as permitted under Chapter 704c of the General Statutes with respect to the liquidation of property of foreign insurers found in this state, and the occurrence of the Mandatory Control Level Event shall be considered adequate grounds for the application.

(Effective September 28, 1994)

Sec. 38a-72-11. Notices

All notices by the commissioner to an insurer which may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the insurer's receipt of such notice.

(Effective September 28, 1994)

Sec. 38a-72-12. Phase-in provision

(a) For RBC Reports required to be filed by property and casualty insurers with respect to 1994, the following requirements shall apply in lieu of the provisions of sections 38a-72-3, 38a-72-4, 38a-72-5, and 38a-72-6:

(1) In the event of a Company Action Level Event with respect to a domestic insurer, the commissioner shall take no regulatory action hereunder.

(2) In the event of a Regulatory Action Level Event under section 38a-72-4 (a) (1), (2), or (3) the commissioner shall take the actions required under section 38a-72-3.

(3) In the event of a regulatory Action Level Event under section 38a-72-4 (a) (4), (5), (6), (7), (8), or (9) or an Authorized Control Level Event, the commissioner shall take the actions required under section 38a-72-4 with respect to the insurer.

(4) In the event of a Mandatory Control Level Event with respect to an insurer, the commissioner shall take the actions required under section 38a-72-5 with respect to the insurer.

(Effective September 28, 1994)

Sec. 38a-72-13. Severability

If any provision of sections 38a-72-1 to 38a-72-13, inclusive, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of sections 38a-72-1 to 38a-72-13, inclusive, which can be given effect without the invalid provision or application, and to that end the above-referenced provisions are severable.

(Effective September 28, 1994)

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Life Reinsurance Agreements

Sec. 38a-72a-1. Preamble

The State of Connecticut Insurance Department recognizes that licensed insurers routinely enter into reinsurance agreements that yield legitimate relief to the ceding insurer from strain to surplus. 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 and 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 herein and described in Section 38a-72a-3 of these regulations would violate Sections 38a-53 and 38a-56 of the General Statutes relating to financial statements which do not properly reflect the financial condition of the ceding insurer, and Sections 38a-85 and 38a-86 of the General Statutes relating to reinsurance reserve credits (thus resulting in a ceding insurer improperly reducing liabilities or establishing assets for reinsurance ceded), and may create a situation that may render the insurer financially hazardous to policyholders and the people of this State.

(Effective January 31, 1994)

Sec. 38a-72a-2. Scope

These regulations, sections 38a-72a-1 to 38a-72a-5, inclusive, shall apply to all domestic life and accident and health insurers and to all other licensed life and accident and health insurers which are not subject to a substantially similar regulation in their domiciliary state. These regulations shall also similarly apply to licensed property and casualty insurers with respect to their accident and health business. These regulations shall not apply to assumption reinsurance, yearly renewable term reinsurance or certain nonproportional reinsurance such as stop loss or catastrophe reinsurance.

(Effective January 31, 1994)

Sec. 38a-72a-3. Accounting requirements

(a) No insurer subject to these regulations shall, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with the Department 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 or assets 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 non-payment 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 or assets;

(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 nor payment by the ceding insurer of an amount equal to *current and* prior years' losses upon voluntary termination of in-force reinsurance by that 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 shall, 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 risk inherent in the business being reinsured. The following table 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 this table.

Risk Categories:

(A) **Morbidity**

(B) **Mortality**

(C) **Lapse.** This is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy.

(D) **Credit Quality.** 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.** 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.** 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 0 = insignificant

	Risk Category					
	A	B	C	D	E	F
Health Insurance—other than LTC/LTD*	+	0	+	0	0	0
Health Insurance—LTC/LTD*	+	0	+	+	+	0
Immediate Annuities	0	+	0	+	+	0
Single Premium Deferred Annuities	0	0	+	+	+	+
Flexible Premium Deferred Annuities	0	0	+	+	+	+
Guaranteed Interest Contracts	0	0	0	+	+	+
Other Annuity Deposit Business	0	0	+	+	+	+
Single Premium Whole Life	0	+	+	+	+	+
Traditional Non-Par Permanent	0	+	+	+	+	+
Traditional Non-Par Term	0	+	+	0	0	0
Traditional Par Permanent	0	+	+	+	+	+
Traditional Par Term	0	+	+	0	0	0
Adjustable Premium Permanent	0	+	+	+	+	+
Indeterminate Premium Permanent	0	+	+	+	+	+
Universal Life Flexible Premium	0	+	+	+	+	+
Universal Life Fixed Premium	0	+	+	+	+	+
Universal Life Fixed Premium dump-in premiums allowed	0	+	+	+	+	+

*LTC = Long Term Care Insurance

*LTD = Longer 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 paragraph (B) of this subdivision) 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, by contract or contract provision, the underlying assets;

(B) Notwithstanding the requirements of paragraph (A) of this subdivision, the assets supporting the reserves for the following 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:

- health insurance—LTC/LTD
- traditional non-par permanent
- traditional par permanent
- adjustable premium permanent
- indeterminate premium permanent
- 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 statutory statement. The following is the accepted formula:

$$\text{Rate} = \frac{2(I+CG)}{X+Y-I-CG}$$

Where:

I = net investment income (exhibit 2, line 16, column 7 of the annual statement)

CG = capital gains less capital losses (exhibit 3, line 10, column 4, plus exhibit 4, line 10, column 4, of the annual statement)

X = 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 = same as X, but for the prior year

Note: Annual statement references pertain to the 1993 annual statement. Such line references may change to reflect changes in subsequent annual statement convention blanks.

(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; or

(11) The reinsurance agreement is entered 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 and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

(b) Notwithstanding Subsection (a) of this section, an insurer subject to these regulations may, with the prior approval of the Commissioner, take such reserve credit as the Commissioner may deem consistent with the Insurance Law, Rules or Regulations, including actuarial interpretations or standards adopted by the Department.

(c) (1) Agreements entered into after the effective date of this regulation 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 within thirty (30) days from its date of execution. Each filing shall include data detailing the financial impact of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this regulation and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with this department. The actuary should maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to this regulation.

(2) Any increase in surplus net of federal income tax resulting from arrangements described in subsection (c) (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 "reserve adjustments on reinsurance ceded" line (for life and accident and health insurers) and in the "aggregate write-ins for underwriting deductions" line (for property and casualty insurers), 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 \$20 million initial commission and expense allowance to company ABC for reinsuring

an existing block of business. Assuming a 34% tax rate, the net increase in surplus at inception is \$13.2 million (\$20 million—\$6.8 million) which is reported on the “aggregate write-ins for gains and losses in surplus” line in the capital and surplus account. \$6.8 million (34% of \$20 million) 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 \$4 million. ABC has paid \$.5 million in profit and risk charges in arrears for the year and has received a \$1 million experience refund. Company ABC’s annual statement would report \$1.65 million 66% of (\$4 million – \$1 million – \$.5 million) up to a maximum of \$13.2 million) on the “commissions and expense allowance on reinsurance” line of the summary of operations, and -\$1.65 million 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.)

(Effective January 31, 1994; amended January 16, 1996)

Sec. 38a-72a-4. Written agreements

(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, 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 that:

(1) 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.

(Effective January 31, 1994)

Sec. 38a-72a-5. Existing agreements

Insurers subject to this regulation shall reduce to zero by December 31, 1995 any reserve credits or assets established with respect to reinsurance agreements entered into prior to the effective date of this regulation which, under the provisions of this regulation would not be entitled to recognition of the reserve credits or assets; provided, however, that the reinsurance agreements shall have been in compliance with the laws or regulations in existence immediately preceding the effective date of this regulation.

(Effective January 31, 1994)

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Connecticut Standard Valuation Law Actuarial Opinion and Memorandum

Sec. 38a-78-1. Purpose

The purpose of sections 38a-78-1 to 38a-78-9, inclusive, of the Regulations of Connecticut State Agencies is to prescribe:

(a) requirements for statements of actuarial opinion that are to be submitted in accordance with subsection (b) of section 38a-78 of the Standard Valuation Law, and for memoranda in support thereof;

(b) rules applicable to the appointment of an appointed actuary; and

(c) guidance as to the meaning of “adequacy of reserves”.

(Effective September 28, 1993; amended December 23, 2008)

Sec. 38a-78-2. Authority

This regulation is promulgated pursuant to the authority vested in the insurance commissioner of the State of Connecticut under sections 38a-78 (b), 38a-(8)(c) and 38a-614(9) of the Connecticut General Statutes.

(Effective September 28, 1993; amended December 23, 2008)

Sec. 38a-78-3. Applicability and scope

Sections 38a-78-1 to 38a-78-9, inclusive, of the Regulations of Connecticut State Agencies shall apply to all life insurance companies and fraternal benefit societies doing business in this state and to all life insurance companies and fraternal benefit societies which are authorized to reinsure life insurance, annuities or accident and health insurance business in this state. Sections 38a-78-1 to 38a-78-9, inclusive, of the Regulations of Connecticut State Agencies shall be applied in a manner which allows the appointed actuary to utilize his or her professional judgment in performing the asset adequacy analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice. However, the commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner’s judgment, these specifications are necessary for an acceptable opinion to be rendered relevant to the adequacy of reserves and related items. Sections 38a-78-1 to 38a-78-9, inclusive, of the Regulations of Connecticut State Agencies shall be applicable to all annual statements filed with the commissioner for the year 2009 and thereafter. A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with section 38a-78-7 of the Regulations of Connecticut State Agencies, and a memorandum in support thereof in accordance with section 38a-78-9 of the Regulations of Connecticut State Agencies, shall be required each year.

(Effective September 28, 1993; amended December 23, 2008)

Sec. 38a-78-4. Definitions

As used in sections 38a-78-1 to 38a-78-9, inclusive of the Regulations of Connecticut State Agencies:

(a) “Actuarial Opinion” means the opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with Section 38a-78-7 of these regulations and with applicable Actuarial Standards of Practice.

(b) “Actuarial Standards Board” means the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

(c) “Annual Statement” means that statement required by Section 38a-53 of the Connecticut General Statutes to be filed by the company with the commissioner annually.

(d) “Appointed Actuary” means any individual who is appointed or retained in accordance with the requirements set forth in subsection (c) of section 38a-78-5 of the Regulations of Connecticut State Agencies to provide the actuarial opinion and supporting memorandum as required by subsection (b) of section 38a-78 of the Standard Valuation Law.

(e) “Asset Adequacy Analysis” means an analysis that meets the standards and other requirements referred to in subsection (d) of section 38a-78-5 of the Regulations of Connecticut State Agencies.

(f) “Commissioner” means the insurance commissioner of the State of Connecticut.

(g) “Company” means a life insurance company, fraternal benefit society or reinsurer subject to the provisions of these regulations.

(h) “NAIC” means the National Association of Insurance Commissioners.

(i) “Qualified Actuary” means any individual who meets the requirements set forth in subsection (b) of section 38a-78-5 of the Regulations of Connecticut State Agencies.

(j) “Standard Valuation Law” means sections 38a-77 and 38a-78 of the Connecticut General Statutes.

(Effective September 28, 1993; amended December 23, 2008)

Sec. 38a-78-5. General requirements

(a) **Submission of Statement of Actuarial Opinion.** (1) There is to be included on or attached to page 1 of the annual statement for each year beginning with the year in which this regulation becomes effective the statement of an appointed actuary, entitled “Statement of Actuarial Opinion,” setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with section 38a-78-7 of the Regulations of Connecticut State Agencies.

In the case of a statement of actuarial opinion required to be submitted by a foreign or alien company, the commissioner may accept the statement of actuarial opinion filed by such company with the insurance supervisory regulator of another state if the commissioner determines that such opinion reasonably meets the requirements applicable to a company domiciled in this state.

(2) Upon written request by the company, the commissioner may grant an extension of the date for submission of the statement of actuarial opinion.

(b) **Qualified Actuary.** A “qualified actuary” is an individual who:

(1) is a member in good standing of the American Academy of Actuaries;

(2) is qualified to sign statements of actuarial opinion for life and health insurance company annual statements 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 subsequently been reinstated as a qualified actuary), 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 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 years, pursuant to this regulation, an actuarial opinion or memorandum that the commissioner rejected because it did not meet the provisions of this regulation including standards set by the Actuarial Standards Board; or

(E) resigned or been removed as an appointed actuary within the past five 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 taken by any insurance commissioner of any other state similar to that under subdivision (4) of this subsection.

(c) **Appointed Actuary.** An “appointed actuary” is a qualified actuary who is appointed or retained to prepare the Statement of Actuarial Opinion required by this regulation, either directly by or by the authority of the board of directors through an executive officer of the company other than the qualified actuary. The 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 such person meets the requirements set forth in subdivision (b) of this section. Once notice is furnished, no further notice is required with respect to this person, provided that the company shall give the commissioner timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in subdivision (b) of this section. 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. An actuary nominated to replace an appointed actuary should consult the previous appointed actuary to determine whether reason exists to decline the appointment. If reason exists to decline the appointment, the source of conflict should be resolved, or the appointment declined.

(d) **Standards for Asset Adequacy Analysis.** The asset adequacy analysis required by this Regulation of the Connecticut State Agencies:

(1) shall conform to the standards of practice as promulgated from time to time by the Actuarial Standards Board and to any additional standards under this Regulation of Connecticut State Agencies, which standards are to form the basis of the statement of actuarial opinion in accordance with section 38a-78-7 of the Regulations of Connecticut State Agencies; and

(2) shall be based on methods of analysis as are deemed appropriate for such purposes by the Actuarial Standards Board.

(e) **Liabilities to be Covered.** (1) Under authority of subsection (b) of section 38a-78 of the Standard Valuation Law, the statement of actuarial opinion shall apply to all in force business on the statement date whether directly issued or assumed regardless of when or where issued, e.g., reserves in the life, accident and health statement Exhibits 5, 6 and 7, and claim liabilities in Exhibit 8, Part 1 and equivalent items in the separate account statement or health statement.

(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 methods set forth in subsections (g), (h), (j), (k) and (l) of section 38a-78 of the Standard Valuation Law, the company shall establish such additional reserve.

(3) Additional reserves established under subdivision (2) of subsection (e) of this section and deemed not necessary in subsequent years may be released. Any amounts 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.

(Effective September 28, 1993; amended December 23, 2008)

Sec. 38a-78-6.

Repealed, December 23, 2008.

Sec. 38a-78-7. Statement of actuarial opinion based on an asset adequacy analysis

(a) **General Description.** The statement of actuarial opinion submitted in accordance with this section shall consist of (1) a paragraph identifying the appointed actuary and his or her qualifications consistent with the requirements of subdivision (1) of subsection (b) of this section; (2) a scope paragraph identifying the subjects on which the opinion is to be expressed and describing 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 in accordance with subdivision (2) of subsection (b) of this section and identifying the reserves and related actuarial items covered by the opinion that may not have been so analyzed; (3) a reliance paragraph, in accordance with subdivision (3) of subsection (b) of this section, describing those areas, if any, where the appointed actuary has deferred to other experts in developing data, procedures, or assumptions such as anticipated cash flows from currently owned assets, including variation in cash flows according to economic scenarios, supported by a statement of each such expert in the form prescribed by subsection (e) of this section; (4) an opinion paragraph, in accordance with subdivision (6) of subsection (b) of this section, expressing the appointed actuary's opinion with respect to the adequacy of the supporting assets to mature the liabilities; (5) one or more additional paragraphs 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 an inconsistency in the method of analysis or basis of asset allocation used at the prior opinion date with that used for this opinion; (C) if the appointed actuary must disclose whether additional reserves as of the prior opinion date are released as of this opinion date, and the extent of the release; (D) if the appointed actuary chooses to add a paragraph briefly describing the assumptions that form the basis for the actuarial opinion.

(b) **Recommended Language.** The following language provided is that which in typical circumstances would be included in a statement of actuarial opinion in accordance with this section. The language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary shall use language which clearly expresses his professional judgment. However, in any event the opinion shall retain all pertinent aspects of the language provided in this Section.

(1) The opening paragraph shall indicate the appointed actuary's relationship to the company and his qualifications to sign the opinion. For a company actuary, the opening paragraph of the actuarial opinion shall include a statement such as:

"I, (name of actuary), am (title) of (name 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 insurer 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 companies.”

For a consulting actuary, the opening paragraph of the actuarial opinion shall contain a sentence such as:

“I, (name and title of actuary), a member of the American Academy of Actuaries, 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 shall contain a sentence such as the following: “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, ().”

Tabulated below are those reserves and related actuarial items that shall be subjected to asset adequacy analysis.

Asset Adequacy Tested Amounts – Reserves and Liabilities					
Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (a) (2)	Analysis Methods (b)	Other Amount (3)	Total Amount (1)+(2)+(3) (4)
Exhibit 5					
Life Insurance					
Annuities					
Supplementary Contracts with Line Contingencies					
Accidental Death Benefits					
Disability – Active Lives					
Disability – Disabled Lives					
Miscellaneous Reserves					
Total Exhibit 5 (Line 1, Page 3)					
Exhibit 6					
Active Life Reserve					
Claim Reserve					
Total Exhibit 6 (Line 2, Page 3)					
Exhibit 7					
Premium and Other Deposit Funds (Column 6, Line 14)					
Guaranteed Interest Contracts (Column 2, Line 14)					

Annuities Certain (Column 3, Line 14)					
Supplemental Contracts (Column 4, Line 14)					
Dividend Accumulations or Refunds (Column 5, Line 14)					
Total Exhibit 7 (Line 3, Page 3)					
Exhibit 8 Part 1 1 Life (Line 4.1, Page 3)					
2 Health (Line 4.2, Page 3)					
Total Exhibit 8 Part 1					
Separate Accounts (Page 3 of the Annual Statement of the Separate Accounts, Lines 1 and 2)					
TOTAL RESERVES					

IMR (General Account, Page _____ Line _____)	
(Separate Accounts, Page _____ Line _____)	
AVR (Page _____ Line _____)	(c)
Net Deferred and Uncollected Premium	

Notes:

- (a) The additional actuarial reserves established under subdivision (2) of subsection (e) of section 38a-78-5 of the Regulations of the Connecticut State Agencies.
- (b) The appointed actuary shall indicate the method of analysis, determined in accordance with the standards for asset adequacy analysis referred to in subsection (d) of section 38a-78-5 of the Regulations of Connecticut State Agencies, by means of symbols that shall be defined in footnotes to the table.
- (c) Allocated amount of Asset Valuation Reserve (AVR).

(3) If the appointed actuary has relied on other experts to develop certain portions of the analysis, the reliance paragraph shall include a statement such as:

“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 own 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 the experts in the form prescribed by subsection (e) of this section.

(4) If the appointed actuary has examined the underlying asset and liability records, the reliance paragraph shall include a statement such as:

“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.”

(5) If the appointed actuary has not examined the underlying records, but has relied upon data such as listings and summaries of policies in force or asset records, prepared by the company, the reliance paragraph shall include a statement such as:

“In forming my opinion on (specify types of 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.”

The section shall be accompanied by a statement by each person relied upon in the form prescribed by subsection (e) of this section.

(6) 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 that 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 the insurance laws of the state of (state of domicile) 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); and

(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 the assets, and the considerations anticipated to be received and retained under the policies and contracts, make adequate provisions, 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.) or (The following material changes which occurred between the date of the statement for which this opinion is applicable and the date of this opinion should be considered in reviewing this opinion: (insert description of the change or changes).

Note: Choose one of the above two paragraphs, whichever is applicable.

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 all the assumptions used in the analysis.

Signature of Appointed Actuary

Address of Appointed Actuary

Telephone Number of Appointed Actuary

Date''

(c) **Assumptions for New Issues.** The adoption for new issues or new claims or other new liabilities of an actuarial assumption that 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) **Adverse Opinions.** 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, then he or she shall issue an adverse or qualified actuarial opinion explicitly stating the reasons for the opinion. This statement shall follow the scope paragraph and precede the opinion paragraph.

(e) **Reliance on Information Furnished by Other Persons.** If the appointed actuary relies on the certification of others on matters concerning the accuracy or completeness of any data underlying the actuarial opinion, or the appropriateness of any other information used by the appointed actuary in forming the actuarial opinion, the actuarial opinion shall so indicate the persons the appointed actuary is relying upon and a precise identification of the items subject to reliance. In addition, the persons on whom the appointed actuary relies shall provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness or reasonableness, as applicable, of the items. This certification shall include the signature, title, company, address and telephone number of the person rendering the certification, as well as the date on which it is signed.

(f) **Alternate Opinion.** (1) As an alternative to the requirements of subparagraph (C) of subdivision (6) of subsection (b) of this section, the commissioner may make one or more of the following additional approaches available to the opining actuary: (A) A statement that the reserves "meet the requirements of the insurance laws and regulations of (the 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 to all insurers. 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; (B) A statement that the reserves "meet the requirements of the insurance laws and regulations of (the state of domicile) and I have verified that the company's request to file an opinion based on the law of the state of domicile has been approved and that any conditions required by the commissioner for approval of that request has 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. It shall remain valid until rescinded or modified by the commissioner. The rescission or modifications shall be issued no later than March 31 of the year they are first effective. Subsequent to that statement being issued, if a company chooses to use this alternative, the company shall annually file a request to do so, along with justification for its use, no later than April 30 of the year in which the opinion is 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; (C) A statement that the reserves “meet the requirements of the insurance laws and regulations of (the state of domicile) and I have submitted the required comparison as specified by this state.” (i) If the commissioner chooses to allow this alternative, a formal written list of products, to be added to the table set forth in subparagraph C(ii) of this subdivision, for which the required comparison is to 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. (ii) If a company chooses 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 the 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 include, at a minimum:

(1) Product Type	(2) Death Benefit or Account Value	(3) Reserves Held	(4) Codification Reserves	(5) Codification Standard

(iii) The information listed shall include all products identified by either the state of filing or any other states subscribing to this alternative. (iv) 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. (v) The comparison provided by the company shall be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

(2) Notwithstanding subsection (f)(1) of this section, 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 Connecticut. If a company is unable to provide the opinion within sixty (60) days of such request or such other period of time determined by the commissioner after consultation with the company, the commissioner may contract with an independent actuary at the company’s expense to prepare and file the opinion.

(Effective September 28, 1993; amended December 23, 2008)

Sec. 38a-78-8.

Repealed, December 23, 2008.

Sec. 38a-78-9. Description of an actuarial memorandum including an asset adequacy analysis and a regulatory asset adequacy issues summary

(a) General.

(1) In accordance with subsection (b) of section 38a-78 of the Standard Valuation Law, 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 pursuant to section 38a-78-7 the Regulations of Connecticut State Agencies. 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.

(2) 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 subsection (b) of section 38a-78-5 of the Regulations of Connecticut State Agencies with respect to the areas covered in such memoranda, and so state in their memoranda.

(3) 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 section, 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 such independent review shall be paid by the company but shall be directed and controlled by the commissioner.

(4) The reviewing actuary shall have the same status as an examiner for purposes of obtaining data from the company and the work papers and documentation of such reviewing actuary shall be retained by the commissioner; provided, however, that any information provided by the company to such 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 section 38a-78 of the general statutes. 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 pursuant to section 38a-78-5 of the Regulations of the Connecticut State Agencies for any one of the current year or the preceding three years.

(5) In accordance with subsection (b) of section 38a-78 of the Standard Valuation Law, the appointed actuary shall prepare a regulatory asset adequacy issues summary, the contents of which are specified in subsection (c) of this section. 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 asset adequacy is required. The regulatory asset adequacy issues summary shall be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

(b) Details of the Memorandum Section Documenting Asset Adequacy Analysis. When an actuarial opinion under section 38a-78-7 of the Regulations of Connecticut State Agencies is provided, the memorandum shall demonstrate that the analysis has been done in accordance with the standards for asset adequacy analysis referred to in subsection (d) of section 38a-78-5 of the Regulations of Connecticut State Agencies and any additional standards under this regulation. It shall specify:

(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 the following:
 - (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) commission and expenses;
 - (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:
 - (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) for the analysis basis:

- (A) methodology;
- (B) rationale for the inclusion/exclusion of different blocks of business and how pertinent risks were analyzed;
- (C) rationale for degree of rigor in analyzing different blocks of business, including the level of materiality that was used in determining how rigorously to analyze different blocks of business;
- (D) criteria for determining asset adequacy, including the precise basis for determining if assets are adequate to cover reserves under “moderately adverse conditions” or other conditions as specified in relevant actuarial standards of practice; 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; and

(6) conclusion.

(c) **Details of the Regulatory Asset Adequacy Issues Summary.** (1) The regulatory asset adequacy issues summary shall include:

(A) 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 shall 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 period 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;

(B) the extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different than the assumptions used in the previous asset adequacy analysis;

(C) 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;

(D) comment on any interim results that may be of significant concern to the appointed actuary;

(E) 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; and

(F) whether the actuary is 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.

(2) The regulatory asset adequacy issues summary shall contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and shall be signed and dated by the appointed actuary rendering the actuarial opinion.

(d) **Conformity to Standards of Practice.** The memorandum shall include the following statement:

“Actuarial methods, considerations and analyses 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.”

(Effective September 28, 1993; amended December 23, 2008)

Sec. 38a-78-10.

Repealed, December 23, 2008.

Minimum Reserve Standards for Individual and Group Health Insurance Contracts

Sec. 38a-78-11. Introduction

(a) **Scope.** Sections 38a-78-11 to 38a-78-16, inclusive, of these regulations shall apply to all individual and group health (accident and sickness) insurance coverages except credit insurance.

When an insurer determines that adequacy of its health insurance reserves requires reserves in excess of the minimum standards specified herein, such increased reserves shall be held and shall be considered the minimum reserves for that insurer.

With respect to any block of contracts, or with respect to an insurer's health business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. Such a gross premium valuation will take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of: all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

Such a gross premium valuation is to be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts, or with respect to the insurer's health business as a whole. In the event inadequacy is found to exist, immediate loss recognition shall be made and the reserves restored to adequacy. Adequate reserves (inclusive of claim, premium and contract reserves, if any) shall be held with respect to all contracts, regardless of whether contract reserves are required for such contracts under these standards.

Whenever minimum reserves, as defined in these standards, exceed reserve requirements as determined by a prospective gross premium valuation, such minimum reserves remain the minimum requirement under these standards.

(b) **Categories of Reserves.** The following sections set forth minimum standards for three categories of health insurance reserves:

Sec. 38a-78-13. Claim reserves

Sec. 38a-78-14. Premium reserves

Sec. 38a-78-15. Contract reserves

Adequacy of an insurer's health insurance reserves is to be determined on the basis of all three categories combined. However, these standards emphasize the importance of determining appropriate reserves for each of the three categories separately.

(c) **Appendices.** These standards contain two appendices: one is an integral part of the standards, and one is a "supplementary" appendix which is not part of the standards as such, but is included for explanatory and illustrative purposes only.

Appendix A. Specific minimum standards with respect to morbidity, mortality and interest, which apply to claim reserves according to year of incurral and to contract reserves according to year of issue.

Appendix B. (Supplementary) Waiver of Premium Reserves.

(Effective September 28, 1993)

Sec. 38a-78-12. Definitions

As used in Sections 38a-78-11 to 38a-78-16, inclusive of these regulations:

(a) "Annual-Claim Cost" means the net annual cost per unit of benefit before the addition of expenses, including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a \$100 monthly disability benefit, for a maximum disability benefit period of one year, with an elimination period of one week, with respect to a male at age 35, in a certain occupation might be \$12, while the gross premium for this benefit might be \$18. The additional \$6 would cover expenses and profit or contingencies.

(b) "Claims Accrued" means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services which have been rendered on or prior to the valuation date,

and for the payment of benefits for days of hospitalization and days of disability which have occurred on or prior to the valuation date, which the insurer has not paid as of the valuation date, but for which it is liable, and will have to pay after the valuation date. This liability is sometimes referred to as a liability for “accrued” benefits. A claim reserve, which represents an estimate of this accrued claim liability, shall be established.

(c) “Claims Reported” means when an insurer has been informed that a claim has been incurred, if the date reported is on or prior to the valuation date, the claim is considered as a reported claim for annual statement purposes.

(d) “Claims Unaccrued” means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services expected to be rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date. This liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made (which may or may not be discounted with interest), shall be established.

(e) “Claims Unreported” means when an insurer has not been informed, on or before the valuation date, concerning a claim that has been incurred on or prior to the valuation date, the claim is considered as an unreported claim for annual statement purposes.

(f) “Date of Disablement” means the earliest date the insured is considered as being disabled under the definition of disability in the contract, based on a doctor’s evaluation or other evidence. Normally this date will coincide with the start of any elimination period.

(g) “Elimination Period” means a specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.

(h) “Guarantee Duration” of a health insurance contract is the maximum number of years the health insurance contract can remain in force on the basis guaranteed in the contract.

(i) “Gross Premium” means the amount of premium charged by the insurer. It includes the net premium (based on claim-cost) for the risk, together with any loading for expenses, profit or contingencies.

(j) “Group Insurance” includes blanket insurance and franchise insurance and any other forms of group insurance.

(k) “Level Premium” means a premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter projected period of years. The premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time. Generally, the annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case the benefit portion of the premium is more than is needed to provide for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums.

(l) “Long-Term Care Insurance” means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one 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 term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health care centers, or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(m) "Modal Premium" means the premium paid on a contract based on a premium term which could be annual, semi-annual, quarterly, monthly, or weekly. Thus, if the annual premium is \$100 and if, instead, monthly premiums of \$9 are paid then the modal premium is \$9.

(n) "Negative Reserve" means the value of the terminal reserve when it is a negative value. Normally the terminal reserve is a positive value. However, if the values of the benefits are decreasing with advancing age or duration it could be a negative value, called a negative reserve.

(o) "Preliminary Term Reserve Method" means that the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium (or stream of changing valuation premiums) becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

(p) "Present Value of Amounts Not Yet Due on Claims" means the reserve for "claims unaccrued" (see definition), which may be discounted at interest.

(q) "Reserve" includes all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued. An insurer under its contracts promises benefits which result in:

(1) claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date. On these claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves; or

(2) claims which are expected to be incurred after the valuation date. Any present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.

(r) "Terminal Reserve" means the reserve at the end of a contract year, and is defined as the present value of benefits expected to be incurred after that contract year minus the present value of future valuation net premiums.

(s) "Unearned Premium Reserve" means that portion of the premium paid or due to the insurer which is applicable to the period of coverage extending beyond the valuation date. Thus, if an annual premium of \$120 was paid on November 1, \$20 would be earned as of December 31 and the remaining \$100 would be unearned.

The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

(t) “Valuation Net Modal Premium” means the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus, if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

(Effective September 28, 1993)

Sec. 38a-78-13. Claim reserves

(a) General.

(1) Claim reserves are required for all incurred but unpaid claims on all health insurance policies.

(2) Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but unpaid claims.

(3) All such reserves for prior valuation years are to be tested for adequacy and reasonableness along the lines of claim runoff schedules in accordance with the statutory financial statement including consideration of any residual unpaid liability.

(b) Minimum Standards for Claim Reserves.

(1) Disability Income.

(A) Interest. The maximum interest rate for claim reserves is specified in Appendix A.

(B) Morbidity. Minimum standards with respect to morbidity are those specified in Appendix A, except that, at the option of the insurer for the portion of claims payable within (i) three years for group disability income claims, or (ii) two years for all other disability claims, from the date of disablement, reserves may be based on the insurer’s experience to the extent that such experience is credible, or, with the approval of the commissioner, upon other assumptions designed to place a sound value on the liabilities.

(C) Duration of Disablement. For contracts with an elimination period, the duration of disablement should be measured as dating from the time that benefits would have begun to accrue had there been no elimination period.

(2) All Other Benefits.

(A) Interest. The maximum interest rate for claim reserves is specified in Appendix A.

(B) Morbidity or Other Contingency. The reserve should be based on the insurer’s experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(c) **Claim Reserve Methods Generally.** Any generally accepted or reasonable actuarial method or combination of methods may be used to estimate all claim liabilities. The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. Approximations based on groupings and averages may also be employed. Adequacy of the claim reserves, however, shall be determined in the aggregate.

(Effective September 28, 1993; amended December 2, 1998)

Sec. 38a-78-14. Premium reserves

(a) General.

(1) Unearned premium reserves are required for all contracts with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

(2) If premiums due and unpaid are carried as an asset, such premiums must be treated as premiums in force, subject to unearned premium reserve determination. The value of unpaid commissions, premium taxes, and the cost of collection associated with due and unpaid premiums must be carried as an offsetting liability.

(3) The gross premiums paid in advance for a period of coverage commencing after the next premium due date which follows the date of valuation may be appropriately discounted to the valuation date and shall be held either as a separate liability or as an addition to the unearned premium reserve which would otherwise be required as a minimum.

(b) **Minimum Standards for Unearned Premium Reserves.**

(1) The minimum unearned premium reserve with respect to any contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with such premium determined on the basis of:

(A) The valuation net modal premium on the contract reserve basis applying to the contract; or

(B) The gross modal premium for the contract if no contract reserve applies.

(2) However, in no event may the sum of the unearned premium and contract reserves for all contracts of the insurer subject to contract reserve requirements be less than the gross modal unearned premium reserve on all such contracts, as of the date of valuation. Such reserve shall never be less than the expected claims for the period beyond the valuation date represented by such unearned premium reserve, to the extent not provided for elsewhere.

(c) **Premium Reserve Methods Generally.** The insurer may employ suitable approximations and estimates, including, but not limited to groupings, averages and aggregate estimation, in computing premium reserves. Such approximations or estimates should be tested periodically to determine their continuing adequacy and reliability.

(Effective September 28, 1993)

Sec. 38a-78-15. Contract reserves

(a) **General.**

(1) Contract reserves are required, unless otherwise specified in subdivision (2) of subsection (a) of this section for:

(A) all individual and group contracts with which level premiums are used; or

(B) all individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. The values specified in this subdivision shall be determined on the basis specified in subsection (b) of this section.

(2) Contracts not requiring a contract reserve are:

(A) Contracts which are not guaranteed renewable after one year from issue; or

(B) Contracts already in force on the effective date of these standards for which no contract reserve was required under the immediately preceding standards.

(3) The contract reserve is in addition to claim reserves and premium reserves.

(4) The methods and procedures for contract reserves should be consistent with those for claim reserves for any contract, or else appropriate adjustment must be made when necessary to assure provision for the aggregate liability. The definition of the date of incurral must be the same in both determinations.

(b) **Minimum Standards for Contract Reserves.**

(1) Basis.

(A) Morbidity or other Contingency. Minimum standards with respect to morbidity are those set forth in Appendix A. Valuation net premiums used under each contract must have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of insured, contract duration and period for which gross premiums have been calculated.

Contracts for which tabular morbidity standards are not specified in Appendix A shall be valued using tables established for reserve purposes by a qualified actuary and acceptable to the Commissioner.

(B) Interest. The maximum interest rate is specified in Appendix A.

(C) Termination Rates. Termination rates used in the computation of reserves shall be on the basis of a mortality table as specified in Appendix A except as noted in the following paragraph.

Under contracts for which premium rates are not guaranteed, and where the effects of insurer underwriting are specifically used by policy duration in the valuation morbidity standard, or for return of premium or other deferred cash benefits, total termination rates may be used at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of:

(i) eighty percent of the total termination rate used in the calculation of the gross premiums; or

(ii) eight percent.

Where a morbidity standard specified in Appendix A is on an aggregate basis, such morbidity standard may be adjusted to reflect the effect of insurer underwriting by policy duration. The adjustments must be appropriate to the underwriting and be accepted to the commissioner.

(D) Reserve Method.

(i) For insurance except long-term care, the minimum reserve is the reserve calculated on the two-year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary.

(ii) For long-term care insurance, the minimum reserve is the reserve calculated on the one-year full preliminary term method.

(iii) For return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated as follows: On the one year preliminary term method if such benefits are provided at any time before the twentieth anniversary;

On the two year preliminary term method if such benefits are only provided on or after the twentieth anniversary.

The preliminary term method may be applied only in relation to the date of issue of a contract. Reserve adjustments introduced later, as a result of rate increases, revisions in assumptions (e.g., projected inflation rates) or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis.

(E) Negative Reserves. Negative reserves on any benefit may be offset against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero.

(c) **Alternative Contract Reserve Valuation Methods and Assumptions Generally.** Provided the contract reserve on all contracts to which an alternative 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 interest rates, termination and/or mortality rates, and rates of morbidity or other contingency. 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 contracts, including, but not limited to the following:

the net level premium method; the one-year full preliminary term method; prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses; the use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, grouping of similar contract forms; the computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued; and the use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

(d) **Tests For Adequacy and Reasonableness of Contract Reserves.** Annually, an appropriate review shall be made of the insurer's prospective contract liabilities on contracts valued by tabular reserves, to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The insurer shall make appropriate increments to such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate; subject, however, to the minimum standards of subsection (b) of this section.

In the event a company has a contract or a group of related similar contracts, for which future gross premiums will be restricted by contract, insurance department regulations, or for other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the company shall establish contract reserves for such shortfall in the aggregate.

(Effective September 28, 1993)

Sec. 38a-78-16. Reinsurance

Increases or offsetting credits to reserves because of reinsurance assumed or reinsurance ceded, must be determined in a manner consistent with minimum reserve standards and with all applicable provisions of the reinsurance contracts which affect the insurer's liabilities.

(Effective September 28, 1993)

Appendix A

Specific Standards for Morbidity, Interest and Mortality

I. Morbidity.

(a) Minimum morbidity standards for valuation of specified individual contract health insurance benefits are as follows (references to Commissioners' Table refers to the valuation table version as opposed to the basic table version as applicable):

(1) Disability Income Benefits Due to Accident or Sickness.

(A) Contract Reserves:

Contracts issued on or after January 1, 1965 and prior to January 1, 1986:

The 1964 Commissioners Disability Table (64 CDT)

Contracts issued on or after January 1, 1994:

The 1985 Commissioners Individual Disability Tables A (85CIDA); or

The 1985 Commissioners Individual Disability Tables B (85CIDB).

Contracts issued during 1986 through 1993:

Optional use of either the 1964 Table or the 1985 Tables.

Each insurer shall elect, with respect to all individual contracts issued in any one statement year, whether it will use Tables A or Tables B as in the minimum standard. The insurer may, however, elect to use other tables with respect to any subsequent statement year.

(B) Claim Reserves:

The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the claim is incurred.

(2) Hospital Benefits, Surgical Benefits and Maternity Benefits (Scheduled benefits or fixed time period benefits only).

(A) Contract Reserves:

Contracts issued on or after January 1, 1955, and before January 1, 1982:

The 1956 Intercompany Hospital-Surgical Tables.

Contracts issued on or after January 1, 1982:

The 1974 Medical Expense Tables, Table A, Transactions of the Society of Actuaries, Volume XXX, pg. 63. Refer to the paper (in the same volume, pg. 9) to which this table is appended, including its discussions, for methods of adjustment for benefits not directly valued in Table A: "Development of the 1974 Medical Expense Benefits," Houghton and Wolf.

(B) Claim Reserves:

No specific standard. See (5).

(3) Cancer Expense Benefits (Scheduled benefits or fixed time period benefits only).

(A) Contract Reserves:

Contracts issued on or after January 1, 1986:

The 1985 NAIC Cancer Claim Cost Tables.

(B) Claim Reserves:

No specific standard. See (5)

(4) Accidental Death Benefits.

(A) Contract Reserves:

Contracts issued on or after January 1, 1965:

The 1959 Accidental Death Benefits Table.

(B) Claim Reserves:

Actual amount incurred.

(5) Other Individual Contract Benefits.

(A) Contract Reserves:

For all other individual contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(B) Claim Reserves:

For all benefits other than disability, claim reserves are to be determined as provided in the standards.

(b) Minimum morbidity standards for valuation of specified group contract health insurance benefits are as follows:

(1) Disability Income Benefits Due to Accident or Sickness.

(A) Contract Reserves:

Contracts issued prior to January 1, 1994: The same basis, if any, as that employed by the insurer as of January 1, 1994;

Contracts issued on or after January 1, 1994:

The 1987 Commissioners Group Disability Income Table (87CGDT).

(B) Claim Reserves:

For claims incurred on or after January 1, 1994:

The 1987 Commissioners Group Disability Income Table (87CGDT);

For claims incurred prior to January 1, 1994:

Use of the 87CGDT is optional.

(2) Other Group Contract Benefits.

(A) Contract Reserves:

For all other group contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(B) Claim Reserves:

For all benefits other than disability, claim reserves are to be determined as provided in the standards.

II. Interest.

(a) For contract reserves the maximum interest rate is the maximum rate permitted by law in the valuation of annual premium ordinary life insurance for appropriate guarantee duration and issued on the same date as the health insurance contract.

(b) For claim reserves on policies for which contract reserve is required, the maximum interest rate is the maximum rate permitted by law in the valuation of annual premium ordinary life insurance for appropriate guarantee duration and issued on the same day as the claim incurral date.

(c) For claim reserves on policies for which no contract reserve is required, the maximum interest rate is the maximum rate permitted by law in the valuation of single premium immediate annuities issued on the same date as the claim incurred date, such rate reduced by one hundred basis points (1%).

III. Mortality.

(a) The mortality basis used shall be according to a table (but without use of selection factors) permitted by law for the valuation of ordinary life insurance issued on the same date as the health insurance contract.

(b) Subject to approval of the commissioner, other mortality tables adopted by the NAIC and promulgated by the Commissioner may be issued in the calculation of the minimum reserves if appropriate for the type of benefits.

(Amended June 22, 1995)

Appendix B

Reserves for Waiver of Premium (Supplementary explanatory material.)

Waiver of premium reserves involve several special considerations. First, the disability valuation tables promulgated by the NAIC are based on exposures that include contracts on premium waiver benefit status as in-force contracts. Hence, contract reserves based on these tables are NOT reserves on "active lives" but rather reserves on contracts "in force." This is true for the 1964 CDT and for both the 1985 CIDA and CIDB tables.

Accordingly, tabular reserves using any of these tables should value reserves on the following basis:

Claim reserves should include reserves for premiums expected to be waived, valuing as a minimum the valuation net premium being waived.

Premium reserves should include contracts on premium waiver benefit status as in-force contracts, valuing as a minimum the unearned modal valuation net premium being waived.

Contract reserves should include recognition of the waiver of premium benefit in addition to other contract benefits provided for, valuing as a minimum the valuation net premium to be waived.

If an insurer is, instead, valuing reserves on what is truly an active life table, or if a specific valuation table is not being used but the insurer's gross premiums are calculated on a basis that includes in the projected exposure only those contracts for which premiums are being paid, then it may not be necessary to provide specifically for waiver of premium reserves. Any insurer using such a true "active life" basis should carefully consider, however, whether or not additional liability should

be recognized on account of premiums waived during periods of disability or during claim continuation.

(Effective September 28, 1993)

Mortality Tables: Minimum Reserve Liabilities

<i>Former Section</i>	<i>New Section</i>
38a-78-1 (re: Mortality Tables)	38a-78-17
38a-78-2 (")	38a-78-18
38a-78-3 (")	38a-78-19
38a-78-4 (")	38a-78-20
38a-78-5 (")	38a-78-21
38a-78-6 (")	38a-78-22
38a-78-7 (")	38a-78-23
38a-78-8 (")	38a-78-24
38a-78-9 (")	38a-78-25

(Effective October 21, 1994)

NAIC Model Regulation Permitting Smoker/Nonsmoker Mortality Tables for Use in Determining Minimum Reserve Liabilities

Sec. 38a-78-17. Purpose

The purpose of Sections 38a-78-18 to 38a-78-20, inclusive, is to permit the use of mortality tables that reflect differences in mortality between smokers and nonsmokers in determining minimum reserve liabilities for plans of insurance with separate premium rates for smokers and nonsmokers.

(Effective September 25, 1992)

Sec. 38a-78-18. Definitions

As used in Sections 38a-78-19 and 38a-78-20:

(a) "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) "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) "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) "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) 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 recommended by the NAIC Technical Staff Actuarial Group.

(f) 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.

(Effective September 25, 1992)

Sec. 38a-78-19. Alternate tables

(a) For any policy of insurance delivered or issued for delivery in this state on or after the date of election pursuant to Section 38a-439 (e) (11) of the General Statutes for that policy form, but prior to January 1, 1989, a company may, subject to the conditions of Section 38a-78-20, substitute for use in determining minimum reserve liabilities: (1) the 1958 CSO Smoker and Nonsmoker Mortality Tables for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors; and (2) the 1958 CET Smoker and Nonsmoker Mortality Tables for the 1980 CET Table. Provided that for any category of insurance issued on female lives with minimum reserve liabilities 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 and before a date not later than January 1, 1989.

(b) For any policy of insurance delivered or issued for delivery in this state on or after the date of election pursuant to Section 38a-439 (e) (11) of the General Statutes for that policy form, a company may, subject to the conditions stated in Section 38a-78-20, substitute for use in determining minimum reserve liabilities: (1) the 1980 CSO Smoker and Nonsmoker Mortality Tables, with or without Ten-Year Select Mortality Factors, for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors; and (2) the 1980 CET Smoker and Nonsmoker Mortality Tables for the 1980 CET Table.

(Effective September 25, 1992)

Sec. 38a-78-20. Conditions

For each plan of insurance with separate rates for smoker and nonsmokers, an insurer may: (a) use composite mortality tables to determine minimum reserve liabilities; (b) use smoker and nonsmoker mortality tables to determine the valuation of net premiums and additional minimum reserves, if any, required by subsection (h) of section 38a-78 of the Connecticut General Statutes and use composite mortality tables to determine the basic minimum reserves; or (c) use smoker and nonsmoker mortality to determine minimum reserve liabilities.

(Effective September 25, 1992)

NAIC Model Regulation for Recognizing New Annuity Mortality Tables For Use In Determining Reserve Liabilities for Annuities

Sec. 38a-78-21. Purpose

The purpose of Sections 38a-78-22 to 38a-78-24, inclusive, is to recognize the following mortality tables for use in determining the minimum standard of valuation

for annuity and pure endowment contracts: the 1983 Table “a”; the 1983 Group Annuity Mortality (1983 GAM) Table; the Annuity 2000 Mortality Table; and the 1994 Group Annuity Reserving (1994 GAR) Table.

(Effective September 25, 1992; amended December 2, 1998)

Sec. 38a-78-22. Definitions

As used in Sections 38a-78-23 and 38a-78-24:

(a) “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.

(b) “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.

(c) “1994 GAR Table” means that mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force and adopted as a recognized mortality table for annuities in December 1996 by the National Association of Insurance Commissioners.

(d) “Annuity 2000 Mortality Table” means that mortality table developed by the Society of Actuaries Committee on Life Insurance Research and adopted as a recognized mortality table for annuities in December 1996 by the National Association of Insurance Commissioners.

(Effective September 25, 1992; amended December 2, 1998)

Sec. 38a-78-23. Individual annuity or pure endowment contracts

(a) Except as provided in subsections (b) and (c) of this section, 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 October 1, 1981.

(b) Except as provided in subsection (c) of this section, 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 December 31, 1985.

(c) Except as provided in subsection (d) of this section, 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, 1999.

(d) The 1983 Table “a” without projection is to be used for determining the minimum standards of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1999, solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:

(1) Settlements of various forms of claims pertaining to court settlements or out of court settlements from tort actions;

(2) Settlements involving similar actions such as worker’s compensation claims; or

(3) Settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

(Effective September 25, 1992; amended December 2, 1998)

Sec. 38a-78-24. Group annuity or pure endowment contracts

(a) Except as provided in subsections (b) and (c) of this section, 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 of these tables may be used for purposes of valuation for any annuity or pure endowment purchased on or after October 1, 1981 under a group annuity or pure endowment contract.

(b) Except as provided in subsection (c) of this section, either 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, 1986 under a group annuity or pure endowment contract.

(c) (1) 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, 1999 under a group annuity or pure endowment contract.

(2) In using the 1994 GAR Table, the mortality rate for a person age x in year $(1994 + n)$ is calculated as follows:

$$q_x^{1994+n} = q_x^{1994}(1-AA_x)^n$$

Where q_x and AA_x s are specified in the 1994 GAR Table.

(Effective September 25, 1992; amended December 2, 1998)

Sec. 38a-78-25. Separability

If any provision of this Regulation 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.

(Effective September 25, 1992)

Sec. 38a-78-26. Purpose

The purpose of sections 38a-78-26 to 38a-78-30, inclusive, of the Regulations of Connecticut State Agencies is to recognize, permit and prescribe the use of the 2001 Commissioners Standard Ordinary (CSO) Mortality Table for use in determining minimum reserve liabilities in accordance with the Standard Valuation Law, subsection (d) of section 38a-78 of the Connecticut General Statutes.

(Adopted effective March 30, 2005)

Sec. 38a-78-27. Definitions

As used in sections 38a-78-26 to 38a-78-30, inclusive, of the Regulations of Connecticut State Agencies:

(a) “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, proposed to the National Association of Insurance Commissioners’ Life and Health Actuarial Task Force at its June 2002 meeting and adopted by the National Association of Insurance Commissioners in December 2002. The 2001 CSO Mortality Table is included in the Proceedings of the NAIC (2nd Quarter 2002). Unless the context indicates otherwise, the “2001 CSO Mortality Table” 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.

(b) “2001 CSO Mortality Table (F)” means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

(c) “2001 CSO Mortality Table (M)” means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

(d) “Composite mortality tables” means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

(e) “Smoker and nonsmoker mortality tables” means mortality tables with separate rates of mortality for smokers and nonsmokers.

(f) “Commissioner” means the Insurance Commissioner.

(Adopted effective March 30, 2005)

Sec. 38a-78-28. 2001 CSO mortality table

(a) At the election of the company for any one or more specified plans of insurance and subject to the conditions stated in Section 38a-78-29 of the Regulations of Connecticut State Agencies, the 2001 CSO Mortality Table may be used as the minimum standard for policies issued after April 1, 2005 and before the date specified in subsection (b) of this section to which subsection (d) of section 38a-78 of the Connecticut General Statutes and subsection (e)(8)(C)(vi) of section 38a-439 of the Connecticut General Statutes are applicable. If the company elects to use the 2001 CSO Mortality Table, it shall do so for both valuation and nonforfeiture purposes. With respect to domestic life insurers only, written notice of election to comply with the provisions of this subsection on or after a specified date shall be filed with the commissioner.

(b) Subject to the conditions stated in Section 38a-78-29 of the Regulations of Connecticut State Agencies, the 2001 CSO Mortality Table shall be used in determining minimum standards for policies issued on and after January 1, 2009 to which subsection (d) of section 38a-78 of the Standard Valuation Law and subsection (e)(8)(C)(vi) of section 38a-439 of the Standard Nonforfeiture Law are applicable.

(Adopted effective March 30, 2005)

Sec. 38a-78-29. Conditions

(a) For each plan of insurance with separate rates for smokers and nonsmokers an insurer may use:

(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 subsection (j) of section 38a-78 of the Connecticut General Statutes and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or

(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.

(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 section 38a-78-5 of the Regulations of Connecticut State Agencies.

(Adopted effective March 30, 2005)

Sec. 38a-78-30. Separability

If any provision of sections 38a-78-26 to 38a-78-29, inclusive, of the Regulations of Connecticut State Agencies or its application to any person or circumstance is for any reason held to be invalid, the remainder of said sections and the application of the provision to other persons or circumstances shall not be affected.

(Adopted effective March 30, 2005)

**Recognition of Preferred Mortality Tables
for Use in Determining Minimum
Reserve Liabilities**

Sec. 38a-78-31. Purpose

The purpose of sections 38a-78-31 to 38a-78-35, inclusive, of the Regulations of Connecticut State Agencies is to recognize, permit and prescribe the use of mortality tables that reflect differences in mortality between Preferred and Standard lives in determining minimum reserve liabilities in accordance with the Standard Valuation Law, subsection (d) of section 38a-78 of the Connecticut General Statutes.

(Adopted effective December 29, 2006)

Sec. 38a-78-32. Definitions

As used in sections 38a-78-31 to 38a-78-35, inclusive, of the Regulations of Connecticut State Agencies:

(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, proposed to the NAIC’s Life and Health Actuarial Task Force at its June 2002 meeting and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the Proceedings of the NAIC (2nd Quarter 2002) and supplemented by the 2001 CSO Preferred Class Structure Mortality Table. Unless the context indicates otherwise, the “2001 CSO Mortality Table” 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. Mortality tables in the 2001 CSO Mortality Table include the following:

- (A) 2001 CSO Mortality Table (F);
- (B) 2001 CSO Mortality Table (M);
- (C) Composite mortality tables; and
- (D) Smoker and nonsmoker 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.

(6) “2001 CSO Preferred Class Structure Mortality Table” means mortality tables with separate rates of mortality for Super Preferred Nonsmokers, Preferred Nonsmokers, Residual Standard Nonsmokers, Preferred Smokers, and Residual Stan-

Standard Smokers splits of the 2001 CSO Nonsmoker and Smoker mortality tables as adopted by the NAIC at the September 2006 national meeting and published in the Proceedings of the NAIC (3rd Quarter 2006). Unless the context indicates otherwise, the “2001 CSO Preferred Class Structure Mortality Table” includes both the ultimate form of that table and the select and ultimate form of that table. It includes both the smoker and nonsmoker mortality tables. It includes both the male and female mortality tables and the gender composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality table.

(7) “Commissioner” means the Insurance Commissioner.

(8) “NAIC” means the National Association of Insurance Commissioners.

(9) “Statistical agent” means an entity with proven systems for protecting the confidentiality of individual insured and insurer information, demonstrated resources for and history of ongoing electronic communications and data transfer ensuring data integrity with insurers, which are its members or subscribers, and a history of and means for aggregation of data and accurate promulgation of the experience modifications in a timely manner.

(Adopted effective December 29, 2006)

Sec. 38a-78-33. 2001 CSO preferred class mortality table

At the election of the company, for each calendar year of issue, for any one or more specified plans of insurance and subject to satisfying the conditions stated in section 38a-78-34 of the Regulations of Connecticut State Agencies, the 2001 CSO Preferred Class Structure Mortality Table may be substituted in place of the 2001 CSO Smoker or Nonsmoker Mortality Table as the minimum valuation standard for policies issued on or after January 1, 2007. For policies issued on or after January 1, 2004, and prior to January 1, 2007, the 2001 CSO Preferred Class Structure Mortality Table may be substituted in place of the 2001 CSO Smoker or Nonsmoker Mortality Table as the minimum valuation standards for such policies with the consent of the commissioner and subject to the conditions of section 38a-78-34 of the Regulations of Connecticut State Agencies. In determining such consent, the commissioner may rely on the consent of the commissioner of the company’s state of domicile. No such election shall be made until the company demonstrates at least twenty percent of the business to be valued on this table is in one or more of the preferred classes. A table from the 2001 CSO Preferred Class Structure Mortality Table used in place of the 2001 CSO Mortality Table, pursuant to the requirements of this section, will be treated as part of the 2001 CSO Mortality Table only for purposes of reserve valuation pursuant to the requirements of the NAIC model regulation, “Recognition of the 2001 CSO Mortality Table For Use In Determining Minimum Reserve Liabilities And Nonforfeiture Benefits Model Regulation”.

(Adopted effective December 29, 2006; amended June 3, 2010)

Sec. 38a-78-34. Conditions

(a) For each plan of insurance with separate rates for Preferred and Standard Nonsmokers lives, an insurer may use the Super Preferred Nonsmokers, Preferred Nonsmokers, and Residual Standard Nonsmokers mortality tables to substitute for the Nonsmokers mortality tables found in the 2001 CSO Mortality Table to determine minimum reserves. At the election and annually thereafter, except for business valued under the Residual Standard Nonsmokers Mortality Table, the appointed actuary shall certify that:

(1) The present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality

improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class; and

(2) The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

(b) For each plan of insurance with separate rates for preferred and standard smokers lives, an insurer may use the Preferred Smokers and Residual Standard Smokers mortality tables to substitute for the Smoker mortality table found in the 2001 CSO Mortality Table to determine minimum reserves. At the time of election and annually thereafter, for business valued under the Preferred Smokers Mortality Table, the appointed actuary shall certify that:

(1) The present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the Preferred Smoker valuation basic table corresponding to the valuation table being used for that class; and

(2) The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvements beyond the valuation date for each class, is less than the present value of death benefits using the Preferred Smoker valuation basic table.

(c) Unless exempted by the commissioner, every authorized insurer using the 2001 CSO Preferred Class Structure Mortality Table shall annually file with the commissioner, with the NAIC, or with a statistical agent designated by the NAIC, and that which is acceptable to the commissioner, statistical reports showing mortality and such other information as the commissioner may deem necessary or expedient for the administration of the provisions of sections 38a-78-1 to 38a-78-34, inclusive of the Regulations of Connecticut State Agencies. The form of the reports shall be established by the commissioner or the commissioner may require the use of a form established by the NAIC or by a statistical agent designated by the NAIC, and that which is acceptable to the commissioner.

(d) The company shall not use the 2001 CSO Preferred Class Structure Mortality Table for the valuation of policies issued on or after January 1, 2004, and prior to January 1, 2007 in any statutory financial statement in which a company reports, with respect to any policy or portion of a policy coinsured, either of the following:

(1) In cases where the mode of payment of the reinsurance premium is less frequent than the mode of payment of the policy premium, a reserve credit that exceeds the gross reserve calculated before reinsurance, by more than the amount specified in this subdivision as Y. Y is the amount of the gross reinsurance premium that (A) provides coverage for the period from the next policy premium due date to the earlier of the end of the policy year or the next reinsurance premium due date, and (B) would be refunded to the ceding entity upon the termination of the policy; or

(2) In cases where the mode of payment of the reinsurance premium is more frequent than the mode of payment of the policy premium, a reserve credit that is less than the gross reserve calculated before reinsurance, by less than the amount specified in this paragraph as Z. Z is the amount of the gross reinsurance premium that the ceding entity would need to pay the assuming company to provide reinsurance

coverage from the period of the next reinsurance premium due date to the next policy premium due date minus any liability established for the proportionate amount not remitted to the reinsurer.

(e) For purposes of subsection (d) of this section, both the reserve credit and the gross reserve before reinsurance (1) for the mean reserve method shall be defined as the mean reserve minus the deferred premium asset, and (2) for the mid-terminal reserve method, shall include the unearned premium reserve. A company may estimate and adjust its accounting on an aggregate basis in order to meet the conditions to use the 2001 CSO Preferred Class Structure Table.

(Adopted effective December 29, 2006; amended June 3, 2010)

Sec. 38a-78-35. Separability

If any provision of sections 38a-78-31 to 38a-78-34, inclusive, of the Regulations of Connecticut State Agencies or its application to any person or circumstance is for any reason held to be invalid, the remainder of said sections and the application of the provision to other persons or circumstances shall not be affected.

(Adopted effective December 29, 2006)

Preneed Life Insurance Minimum Standards for Determining Reserve Liabilities and Nonforfeiture Values Model

Sec. 38a-78-36. Authority

This regulation is promulgated by the Insurance Commissioner pursuant to section 38a-78 of the Connecticut General Statutes.

(Adopted effective April 2, 2009)

Sec. 38a-78-37. Scope

This section applies to preneed insurance contracts, as defined in section 38a-78-39 of the Regulations of Connecticut State Agencies, and to similar policies and certificates.

(Adopted effective April 2, 2009)

Sec. 38a-78-38. Purpose

The purpose of this regulation is to establish for preneed insurance products minimum mortality standards for reserves and nonforfeiture values, and to require the use of the 1980 Commissioners Standard Ordinary (CSO) Life Valuation Mortality Table for use in determining the minimum standard of valuation of reserves and the minimum standard nonforfeiture values for preneed insurance products.

(Adopted effective April 2, 2009)

Sec. 38a-78-39. Definitions

As used in Sections 38a-78-36 to 38a-78-44, inclusive of the Regulations of Connecticut State Agencies:

(1) The term “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 NAIC in December 2002. The 2001 CSO Mortality Table is included in the Proceedings of the NAIC (2nd Quarter 2002). Unless the context indicates otherwise, the “2001 CSO Mortality Table” 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) The term “Ultimate 1980 CSO” means the Commissioners’ 1980 Standard Ordinary Life Valuation Mortality Tables (1980 CSO) without ten-year (10-year) selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law approved in December 1983.

(3) “NAIC” means the National Association of Insurance Commissioners.

(4) “Preneed insurance” means any life insurance policy or certificate that is issued in combination with, in support of, with an assignment to, or as a guarantee for a prearrangement agreement for goods and services to be provided at the time of and immediately following the death of the insured. Goods and services may include, but are not limited to, embalming, cremation, body preparation, viewing or visitation, coffin or urn, memorial stone, and transportation of the deceased. The status of the policy or contract as preneed insurance is determined at the time of issue in accordance with the policy form filing.

(Adopted effective April 2, 2009)

Sec. 38a-78-40. Minimum valuation mortality standards

For preneed insurance contracts and similar policies and contracts, the minimum mortality standard for determining reserve liabilities and non-forfeiture values for both male and female insureds shall be the Ultimate 1980 CSO.

(Adopted effective April 2, 2009)

Sec. 38a-78-41. Minimum valuation interest rate standards

(a) The interest rates used in determining the minimum standard for valuation of preneed insurance shall be the calendar year statutory valuation interest rates as defined in section 38a-78 of the Connecticut General Statutes.

(b) The interest rates used in determining the minimum standard for nonforfeiture values for preneed insurance shall be the calendar year statutory nonforfeiture interest rates as defined in section 38a-439(e) of the Connecticut General Statutes.

(Adopted effective April 2, 2009)

Sec. 38a-78-42. Minimum valuation method standards

(a) The method used in determining the standard for the minimum valuation of reserves of preneed insurance shall be the method defined in section 38a-78 of the Connecticut General Statutes.

(b) The method used in determining the standard for the minimum nonforfeiture values for preneed insurance shall be the method defined in section 38a-78 of the Connecticut General Statutes.

(Adopted effective April 2, 2009)

Sec. 38a-78-43. Transition rules

(a) For preneed insurance policies issued on or after the effective date of this regulation and before January 1, 2012, the 2001 CSO may be used as the minimum standard for reserves and minimum standard for non-forfeiture benefits for both male and female insureds.

(b) If an insurer elects to use the 2001 CSO as a minimum standard for any policy issued on or after the effective date of this regulation and before January 1, 2012, the insurer shall provide, as a part of the actuarial opinion memorandum submitted in support of the company’s asset adequacy testing, an annual written notification to the domiciliary commissioner. The notification shall include:

(1) A complete list of all preneed policy forms that use the 2001 CSO as a minimum standard;

(2) A certification signed by the appointed actuary stating that the reserve methodology employed by the company in determining reserves for the preneed policies issued after the effective date and using the 2001 CSO as a minimum standard, develops adequate reserves (for the purposes of this certification, the preneed insurance policies using the 2001 CSO as a minimum standard cannot be aggregated with any other policies); and

(3) Supporting information regarding the adequacy of reserves for preneed insurance policies issued after the effective date of this regulation and using the 2001 CSO as a minimum standard for reserves.

(c) Preneed insurance policies issued on or after January 1, 2012, shall use the Ultimate 1980 CSO in the calculation of minimum nonforfeiture values and minimum reserves.

(Adopted effective April 2, 2009)

Sec. 38a-78-44. Effective date

This regulation is applicable to preneed insurance policies and certificates and similar contracts and certificates issued on or after January 1, 2009.

(Adopted effective April 2, 2009)

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Credit for Reinsurance

Sec. 38a-88-1. Credit for reinsurance—reinsurer licensed in this state

(a) The Commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that was licensed in this state as of any date on which statutory financial statement credit for reinsurance is claimed.

(b) As used in sections 38a-88-1 to 38a-88-12, inclusive, of the Regulations of Connecticut State Agencies:

(1) “Commissioner” means the Insurance Commissioner of the State of Connecticut;

(2) “Evergreen” means that a letter of credit will be continuously renewed unless the financial institution which issued or confirmed the letter of credit gives advance notice that it will not be renewed when its term expires;

(3) “Liabilities” means the assuming insurer’s gross liabilities attributable to reinsurance ceded by U. S. domiciled insurers that are not otherwise secured by acceptable means, and, shall include: (A) For business ceded by domestic insurers authorized to write property and casualty insurance: (i) Losses and allocated loss expenses paid by the ceding insurer, recoverable from the assuming insurer; (ii) Reserves for losses reported and outstanding; (iii) Reserves for losses incurred but not reported; (iv) Reserves for allocated loss expenses; and (v) Unearned premiums; (B) For business ceded by domestic insurers authorized to write life, health and annuity insurance: (i) Aggregate reserves for life policies and contracts net of policy loans and net due and deferred premiums; (ii) Aggregate reserves for accident and health policies; (iii) Deposit funds and other liabilities without life or disability contingencies; and (iv) Liabilities for policy and contract claims; and

(4) “NAIC” means the National Association of Insurance Commissioners.
(Effective November 26, 1991; amended July 7, 2004)

Sec. 38a-88-2. Credit for reinsurance—accredited reinsurers

(a) The Commissioner 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 any date on which statutory financial statement credit for reinsurance is claimed. An accredited reinsurer is one which:

(1) Files a properly executed Form AR-1 (Appendix A of this regulation) as evidence of its submission to this state’s jurisdiction and to this state’s authority to examine its books and records;

(2) Files annually by March 1 with the Commissioner a certified copy of a certificate of authority or other acceptable evidence that it is licensed to transact insurance or reinsurance in at least one 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 state;

(3) Files annually by March 1 with the Commissioner a copy of its annual statement filed with the insurance department 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

(A) Maintains a surplus as regards policyholders in an amount not less than \$20,000,000 and whose accreditation has not been denied by the Commissioner within 90 days of its submission; or (B) Maintains a surplus as regards policyholders of less than \$20,000,000, and whose accreditation has been approved by the Commissioner.

(b) If the Commissioner determines that the assuming insurer has failed to meet or maintain any of these qualifications, the Commissioner may upon written notice and hearing revoke the accreditation. Credit shall not be allowed a domestic ceding insurer if the assuming insurer's accreditation has been revoked by the Commissioner.

(Effective November 26, 1991; amended July 7, 2004)

Sec. 38a-88-3. Credit for reinsurance—Reinsurer domiciled in another state

(a) The Commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that as of any date on which statutory financial statement credit for reinsurance is claimed:

(1) Is domiciled in (or, in the case of a United States branch of an alien assuming insurer, is entered through) a state which employs standards regarding credit for reinsurance substantially similar to those applicable under Sections 38a-85 to 38a-89, inclusive, of the General Statutes and this regulation;

(2) Maintains a surplus as regards policyholders in an amount not less than \$20,000,000; and

(3) Files a properly executed Form AR-1 (Appendix A of this regulation) with the Commissioner as evidence of its submission to this 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 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 determines equal or exceed the standards of Sections 38a-85 to 38a-89, inclusive, of the General Statutes and this regulation.

(c) Notwithstanding subsection (a) of this section, the Commissioner shall allow credit for reinsurance ceded and assumed to a pooling arrangement that has the following characteristics:

(1) The majority of the pooling members are licensed to transact business in this state;

(2) The members of the pool are subject to several or joint and several liability;

(3) All members of the pool agree to file annually on or before March 1 with the Commissioner a copy of its annual statement filed with the insurance department of its state of domicile; and

(4) The manager of the pool files annually by December 1 with the Commissioner a request to be exempted from the provisions of subsection (a) of this section.

(Effective November 26, 1991; amended July 7, 2004)

Sec. 38a-88-4. Credit for reinsurance—Reinsurers maintaining trust funds

(a) The Commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which, as of any date on which statutory financial statement credit for reinsurance is claimed, and thereafter for so long as credit for reinsurance is claimed, maintains a trust fund in an amount prescribed below in a qualified United States financial institution as defined in Section 38a-87(b) of the General Statutes, for the payment of the valid claims of its United States domiciled ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the Commissioner substantially the same information as that required to be reported on the NAIC annual statement form by licensed insurers, to enable the Commissioner 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 reinsurance ceded by United States domiciled insurers, and in addition, the assuming insurer shall maintain a trustee surplus of not less than \$20,000,000.

(2) (A) The trust fund for a group including incorporated and individual unincorporated underwriters shall consist of:

(i) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after August 1, 1995, funds in trust in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group;

(ii) For reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of sections 38a-88-1 to 38a-88-12, inclusive, of the Regulations of Connecticut State Agencies, funds in trust in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States; and

(iii) In addition to these trusts, the group shall maintain a trustee surplus of which \$100,000,000 shall be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all the years of account.

(B) 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 regulation and solvency control by the group's domiciliary regulator as are the unincorporated members. The group shall, within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, provide to the commissioner:

(i) An annual certification by the group's domiciliary regulator of the solvency of each underwriter member of the group; or

(ii) If a certification is unavailable, a financial statement, audited by independent public accountants, of each underwriter member of the group.

(3) Within 90 days after the statements are due to be filed with the group's domiciliary regulator, the group shall file with the commissioner an annual certification of each underwriter member's solvency by the member's domiciliary regulators, and financial statements, audited by independent public accountants, of each underwriter member of the group.

(c) (1) Credit for reinsurance shall not be granted unless the form of the trust and any amendments to the trust have been approved by either the commissioner of the state where the trust is domiciled or the commissioner of another state who, pursuant to the terms of the trust instrument, has accepted responsibility for regulatory oversight of the trust. The form of the trust and any trust amendments also shall be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that:

(A) Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied 30 days after entry of the final order of any court of competent jurisdiction in the United States.

(B) Legal Title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's United States ceding insurers, their assigns and successors in interest.

(C) The trust shall be subject to examination as determined by the Commissioner.

(D) 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.

(E) No later than March 1 of each year the trustee of the trust shall report to the Commissioner in writing setting forth the balance in the trust and listing the trust's investment 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.

(2)(A) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by this subsection or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight over the trust all of the assets of the trust fund.

(B) The assets shall be distributed by and claims shall be filed with and valued by the commissioner with regulatory oversight over the trust in accordance with the laws of the state in which the trust is domiciled applicable to the liquidation of domestic insurance companies.

(C) If the commissioner with regulatory oversight over the trust determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States beneficiaries of the trust, the commissioner with regulatory oversight over the trust shall return the assets, or any part thereof, to the trustee for distribution in accordance with the trust agreement.

(D) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with the provisions of this subsection, including actions pursuant to Section 304 of the Federal Bankruptcy Act seeking repatriation of trust assets for distribution in a non-United States liquidation proceeding.

(d) Assets deposited in trusts established pursuant to Section 38a-85 of the General Statutes and this section shall be valued according to their fair market value and shall consist only of cash in United States dollars, certificates of deposit issued by a qualified United States financial institution as defined in Section 38a-87(a) of the General Statutes, clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified United States financial institution, as defined in Section 38a-87(a) of the General Statutes, and investments of the type specified in this subsection, but investments in or issued by an entity controlling, controlled by or under common control with either the grantor or beneficiary of the trust shall not exceed five percent (5%) of total investments. No more than twenty percent (20%) of the total of the investments in the trust may be foreign investments authorized under subparagraph (E) of subdivision (1) of this subsection, subparagraph (B) of subdivision (6) of this subsection, or subdivision (3) or (7) of this subsection, and no more than ten percent (10%) of the total of the investments in the trust may be securities denominated in foreign currencies. For purposes of applying the preceding sentence, a depository receipt denominated in United States dollars and representing rights conferred by a foreign security shall be classified as a foreign investment denominated in a foreign currency. The assets of a trust established to satisfy the requirements of Section 38a-85 of the General Statutes shall be invested only as follows:

(1) Government obligations that are not in default as to principal or interest, that are valid and legally authorized and that are issued, assumed or guaranteed by: (A)

The United States or by any agency or instrumentality of the United States; (B) A state of the United States; (C) A territory, possession or other governmental unit of the United States; (D) An agency or instrumentality of a state, territory, possession or other governmental unit referred to in subparagraph (B) or (C) of this subdivision if the obligations shall be by law (statutory or otherwise) payable, as to both principal and interest, from taxes levied or by law required to be levied or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for making these payments, but shall not be obligations eligible for investment under this subdivision if payable solely out of special assessments on properties benefited by local improvements; or (E) The government of any other country that is a member of the Organization for Economic Cooperation and Development and whose government obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

(2) Obligations that are issued in the United States, or that are dollar denominated and issued in a non- United States market, by a solvent United States. institution (other than an insurance company) or that are assumed or guaranteed by a solvent United States institution (other than an insurance company) and that are not in default as to principal or interest if the obligations:

(A) Are rated A or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC, or if not so rated, are similar in structure and other material respects to other obligations of the same institution that are so rated;

(B) Are insured by at least one authorized insurer (other than the investing insurer or a parent, subsidiary or affiliate of the investing insurer) licensed to insure obligations in this state and, after considering the insurance, are rated AAA (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC; or

(C) Have been designated as Class One or Class Two by the Securities Valuation Office of the NAIC;

(3) Obligations issued, assumed or guaranteed by a solvent non-United States institution chartered in a country that is a member of the Organization for Economic Cooperation and Development or obligations of United States corporations issued in a non- United States currency, provided that in either case the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

(4) An investment made pursuant to the provisions of subdivision (1), (2) or (3) of this subsection shall be subject to the following additional limitations:

(A) An investment in or loan upon the obligations of an institution other than an institution that issues mortgage-related securities shall not exceed five percent (5%) of the assets of the trust;

(B) An investment in any one mortgage-related security shall not exceed five percent (5%) of the assets of the trust;

(C) The aggregate total investment in mortgage-related securities shall not exceed twenty-five percent (25%) of the assets of the trust; and

(D) Preferred or guaranteed shares issued or guaranteed by a solvent United States institution are permissible investments if all of the institution's obligations are eligible as investments under subparagraphs (A) and (C) of subdivision (2) of this subsection, but shall not exceed two percent (2%) of the assets of the trust.

(5) As used in this section:

(A) “Mortgage-related security” means an obligation that is rated AA or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC and that either:

(i) Represents ownership of one or more promissory notes or certificates of interest or participation in the notes (including any rights designed to assure servicing of, or the receipt or timeliness of receipt by the holders of the notes, certificates, or participation of amounts payable under, the notes, certificates or participation), that:

(I) Are directly secured by a first lien on a single parcel of real estate, including stock allocated to a dwelling unit in a residential cooperative housing corporation, upon which is located a dwelling or mixed residential and commercial structure, or on a residential manufactured home as defined in 42 USC Section 5402(6), whether the manufactured home is considered real or personal property under the laws of the state in which it is located; and

(II) Were originated by a savings and loan association, savings bank, commercial bank, credit union, insurance company, or similar institution that is supervised and examined by a federal or state housing authority, or by a mortgagee approved by the Secretary of Housing and Urban Development pursuant to 12 USC Sections 1709 and 1715b, or, where the notes involve a lien on the manufactured home, by an institution or by a financial institution approved for insurance by the Secretary of Housing and Urban Development pursuant to 12 USC Section 1703; or

(ii) Is secured by one or more promissory notes or certificates of deposit or participations in the notes (with or without recourse to the insurer of the notes) and, by its terms, provides for payments of principal in relation to payments, or reasonable projections of payments, or notes meeting the requirements of subclauses (i)(I) and (i)(II) of this subsection;

(B) “Promissory note” when used in connection with a manufactured home, shall also include a loan, advance or credit sale as evidenced by a retail installment sales contract or other instrument.

(6) Equity interests

(A) Investments in common shares or partnership interests of a solvent U. S. institution are permissible if:

(i) The institution’s obligations and preferred shares, if any, are eligible as investments under this subsection; and

(ii) The equity interests of the institution (except an insurance company) are registered on a national securities exchange as provided in the Securities Exchange Act of 1934, 15 USC Sections 78a to 78kk, inclusive, or otherwise registered pursuant to that Act, and if otherwise registered, price quotations for the equity interests are furnished through a nationwide automated quotations system approved by the National Association of Securities Dealers, Inc. A trust shall not invest in equity interests under this subparagraph an amount exceeding one percent (1%) of the assets of the trust even though the equity interests are not so registered and are not issued by an insurance company; (B) Investments in common shares of a solvent institution organized under the laws of a country that is a member of the Organization for Economic Cooperation and Development, are permissible if:

(i) All the institution’s obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC; and

(ii) The equity interests of the institution are registered on a securities exchange regulated by the government of a country that is a member of the Organization for Economic Cooperation and Development;

(C) An investment in or loan upon any one institution's outstanding equity interests shall not exceed one percent (1%) of the assets of the trust. The cost of an investment in equity interests made pursuant to this subparagraph, when added to the aggregate cost of other investments in equity interests then held pursuant to this subparagraph, shall not exceed ten percent (10%) of the assets in the trust;

(7) Obligations issued, assumed or guaranteed by a multinational development bank, provided the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC.

(8) Investment companies

(A) Securities of an investment company registered pursuant to the Investment Company Act of 1940, 15 USC Sections 80a-1 et seq., are permissible investments if the investment company:

(i) Invests at least ninety percent (90%) of its assets in the types of securities that qualify as an investment under subdivision (1), (2) or (3) of this subsection or invests in securities that are determined by the commissioner to be substantively similar to the types of securities set forth in subdivisions (1), (2) or (3) of this subsection; or

(ii) Invests at least ninety percent (90%) of its assets in the types of equity interests that qualify as an investment under subparagraph (A) of subdivision (6) of this subsection;

(B) Investments made by a trust in investment companies under this subdivision shall not exceed the following limitations:

(i) An investment in an investment company qualifying under subparagraph (A)(i) of this subdivision shall not exceed ten percent (10%) of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall not exceed twenty-five percent (25%) of the assets in the trust; and

(ii) Investments in an investment company qualifying under subparagraph (A)(ii) of this subdivision shall not exceed five percent (5%) of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall be included when calculating the permissible aggregate value of equity interests pursuant to subparagraph (A) of subdivision (6) of this subsection.

(9) Letters of Credit

(A) In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the commissioner) to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

(B) The trust agreement shall provide that the trustee shall be liable for damages caused by its own negligence, willful misconduct or lack of good faith, including the failure of the trustee to draw against the letter of credit in circumstances where such draw would be required.

(e) A specific security provided to a ceding insurer by an assuming insurer pursuant to Section 38a-88-6 of the Regulations of Connecticut State Agencies shall be applied, until exhausted, to the payment of liabilities of the assuming insurer to the ceding insurer holding the specific security prior to, and as a condition precedent for, presentation of a claim by the ceding insurer for payment by a trustee of a trust established by the assuming insurer pursuant to this section.

(Effective November 26, 1991; amended July 7, 2004)

Sec. 38a-88-5. Credit for reinsurance required by law

Pursuant to Section 38a-85(f) of the General Statutes, the Commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Subsections (b), (c), (d) or (e) of Section 38a-85 of the General Statutes, but only as to the insurance of risks located in jurisdictions where the 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.

(Effective November 26, 1991; amended July 7, 2004)

Sec. 38a-88-6. Reduction from liability for reinsurance ceded to an unauthorized assuming insurer

(a) Pursuant to Section 38a-86 of the General Statutes, the Commissioner shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section 38a-85 of the General Statutes in an amount not exceeding the liabilities carried by the ceding insurer. The 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 under the reinsurance contract. The security shall 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 Section 38a-87(b) of the General Statutes. This security 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 Section 38a-87(a) of the Statutes, effective no later than December 31 of the year for which filing is being made, and in the possession of, or in trust for, 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) institution's 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.

(b) An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to this section shall be allowed only when the requirements of Sections 38a-88-7, 38a-88-8, or 38a-88-9 of this regulation have been satisfied.

(Effective November 26, 1991; amended July 7, 2004)

Sec. 38a-88-7. Trust agreements used to qualify for reduction from liability for reinsurance ceded to an unauthorized assuming insurer

(a) As used in 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, including without limitation any liquidator, rehabilitator, receiver or conservator. When estab-

lished in conjunction with a reinsurance agreement the beneficiary is the licensed ceding insurer.

(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) of this section, means:

(A) Reinsurance losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;

(B) Reserves for reinsured losses reported and outstanding;

(C) Reserves for reinsured losses incurred but not reported; and

(D) Reserves for allocated reinsured loss expenses and unearned premiums.

(b) Required conditions for trust agreements qualified under Section 38a-88-6.

(1) The trust agreement shall be entered into between the beneficiary, the grantor and a trustee which shall be a qualified United States financial institution as defined in Section 38a-87(b) of the General Statutes.

(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.

(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 represented 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) of this subsection.

(5) The trust agreement shall be established for the sole benefit of the beneficiary.

(6) The trust agreement shall require the trustee to:

(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 frequent 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 such assets to such beneficiary; and

(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. In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the Commissioner) to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

(10) The trust agreement shall provide that the trustee shall be liable for damages caused by its own negligence, willful misconduct or lack of good faith, including the failure of the trustee to draw against the letter of credit in circumstances where such draw would be required.

(11) Notwithstanding other provisions of this regulation, 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, the trust agreement may 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 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 102 percent of the actual amount required to fund the assuming insurer's "obligations" under the specific reinsurance agreement; or

(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 ten (10) days prior to such termination date, to withdraw amounts equal to such obligations and deposit such amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution as defined in Section 38a-87(b) of the General Statutes apart from its general assets, in trust for such uses and purposes specified in subparagraphs (A) and (B) above, as may remain executory after such withdrawal and for any period after such termination date.

(12) Notwithstanding other provisions of sections 38a-88-1 to 38a-88-12, inclusive, of the Regulations of Connecticut State Agencies, when a trust agreement is established to meet the requirements of Section 38a-88-6 of the Regulations of Connecticut State Agencies in conjunction with a reinsurance agreement covering life, annuities or accident and health risks, where it is customary to provide a trust agreement for a specific purpose, the trust agreement may 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, only for the following purposes:

(A) To pay or reimburse the ceding insurer for:

(i) The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners

of policies reinsured under the reinsurance agreement on account of cancellations of the policies; and

(ii) The assuming insurer's share under the specific reinsurance agreement of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurer, under the terms and provisions of the policies reinsured under the reinsurance agreement;

(B) To pay to the assuming insurer amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer; or

(C) Where the ceding insurer has received notification of termination of the trust and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer, and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution apart from its general assets, in trust for the uses and purposes specified in subparagraphs (A) and (B) of this subdivision as may remain executory after withdrawal and for any period after the termination date.

(13) The reinsurance agreement may, but need not, contain the provisions required by Subsection (d)(1)(B) of this section, so long as these required conditions are included in the trust agreement.

(c) Permitted conditions for trust agreements qualified under Section 38a-88-6.

(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 the beneficiary and grantor receive the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after the trustee and the beneficiary receive 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 dividends 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 such funds and to accept such 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) of this section.

(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) Additional conditions applicable to reinsurance agreements.

(1) A reinsurance agreement may contain provisions that:

(A) require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what such 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 cash in (United States dollars), certificates of deposit (issued by a United States bank and payable in United States dollars), and investments of the types permitted by the Insurance Code or any combination of the above, provided investments in or issued by an entity controlling, controlled by or under common control with either the grantor or the beneficiary of the trust shall not exceed five percent (5%) of total investments. 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 and accident and health, then the trust agreement may contain the provisions required by this subparagraph 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, endorsements in blank, or 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 any such 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; and

(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 pay or reimburse the ceding insurer for: (I) the assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

(II) 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; and

(III) any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(ii) To make payment to the assuming insurer of amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(2) The reinsurance agreement may also contain provisions that:

(A) give the assuming insurer the right to seek approval from the ceding insurer, which shall not be unreasonably or arbitrarily withheld, 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 such 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 such withdrawal and transfer, the market value of the trust account is no less than 102 percent of the required amount. The ceding insurer shall not unreasonably or arbitrarily withhold its approval.

(B) provide for the return of any amount withdrawn in excess of the actual amounts required for subparagraph (E) of subdivision (1) of this subsection, and for interest payments at a rate not in excess of the prime rate of interest on the amounts held pursuant to subparagraph (E) of subdivision (1) of this subsection;

(C) permit the award by any arbitration panel or court of competent jurisdiction of:

(i) interest at a rate different from that provided in subparagraph (B) of subdivision (2) of this subsection;

(ii) court or arbitration costs;

(iii) attorney's fees; and

(iv) any other reasonable expenses.

(3) Financial reporting. 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 this Department in compliance with the provisions of this regulation 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) Existing agreements. Notwithstanding the effective date of this regulation, any trust agreement or underlying reinsurance agreement in existence prior to July 1, 1991 will continue to be acceptable until June 30, 1992, at which time the agreements will have to be in full compliance with this regulation for the trust agreement to be acceptable.

(5) The failure of any trust agreement to specifically identify the beneficiary as defined in subsection (a) of this section shall not be construed to affect any actions or rights which the Commissioner may take or possess pursuant to the provisions of the laws of this state.

(Effective November 26, 1991; amended July 7, 2004, May 30, 2007)

Sec. 38a-88-8. Letters of credit used to qualify for reduction from liability for reinsurance ceded to an unauthorized assuming insurer

(a) The letter of credit must be clean, irrevocable, unconditional and issued or confirmed by a qualified United States financial institution as defined in Section 38a-87(a) of the General Statutes. The letter of credit shall contain an issue date and expiration date 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) of this section. 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 such 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 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 30 days' notice prior to expiration date or non-renewal.

(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) or any successor publication, and all drafts 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), or any successor publication, then the letter of credit shall specifically address and provide for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 17 of Publication 500 or any other successor publication occur.

(g) The letter of credit shall be issued or confirmed by a qualified United States financial institution authorized to issue letters of credit, pursuant to Section 38a-87(a) of the General Statutes.

(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) of this section, 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, and

(2) The "evergreen clause" shall provide for 30 days notice prior to expiration date for non-renewal.

(i) Reinsurance agreement provisions.

(1) The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions that:

(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 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 provisions in such agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

(i) to pay or reimburse the ceding insurer for: (I) the assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurers, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

(II) the assuming insurer's share, under the specific reinsurance agreement, of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurers, under the terms and provisions of the policies reinsured under the reinsurance agreement; and

(III) any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer;

(ii) where the letter of credit will expire without renewal or be reduced or replaced by a letter of credit for a reduced amount and where the assuming insurer's entire obligations under the specific reinsurance remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of the liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer and exceed the amount of any reduced or replacement letter of credit, and deposit those amounts in a separate account in the name of the ceding insurer in a qualified United States financial institution apart from its general assets, in trust for such uses and purposes specified in Subdivision (1)(B)(i) of this subsection as may remain after withdrawal and for any period after the termination date.

(C) All of the following provisions of Subdivision (1) of this subsection shall be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

(2) Nothing contained in Subdivision (1) of this subsection shall preclude the ceding insurer and assuming insurer from providing for:

(A) an interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to Subsection (i)(1)(B) of this section; or

(B) the return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or any amounts that are subsequently determined not to be due.

(Effective November 26, 1991; amended July 7, 2004)

Sec. 38a-88-9. Other security

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.

(Effective November 26, 1991; amended July 7, 2004)

Sec. 38a-88-10. Reinsurance contract

Credit will not be granted, nor an asset or reduction from liability allowed, to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of Sections 38a-88-1 to 38a-88-4, inclusive, and Section 38a-88-6 of this regulation or otherwise in compliance with Section 38a-85 of the General Statutes after the adoption of this regulation unless the reinsurance agreement:

(a) Includes a proper insolvency clause that provides, in substance, that in the event of the insolvency of the ceding insurer, the reinsurance shall be payable under a reinsurance agreement entered into by the assuming insurer on the basis of reported claims allowed by the liquidation court, without diminution because of the insolvency of the ceding insurer. Such payments shall be made directly to the ceding insurer or to its domiciliary liquidator except: (1) where the contract or other written agreement specifically provides another payee of such reinsurance in the event of the insolvency of the ceding insurer, or (2) where the assuming insurer, with the consent of the direct insured(s), has assumed such policy obligations of the ceding

insurer as direct obligations of the assuming insurer to the payees under such policies and in substitution for the obligations of the ceding insurer to such payees;

(b) Notwithstanding subsection (a) of this section, in the event that a life and health insurance guaranty association has made the election to succeed to the rights and obligations of the insolvent insurer under the contract of reinsurance, then the reinsurer's liability to pay covered reinsured claims shall continue under the contract of reinsurance, subject to the payment to the reinsurer of the reinsurance premiums for such coverage. Payment for such reinsured claims shall only be made by the reinsurer pursuant to the direction of the guaranty association or its designated successor. Any payment made at the direction of the guaranty association or its designated successor by the reinsurer will discharge the reinsurer of all further liability to any other party for said claim payment;

(c) The reinsurance agreement may provide that the domiciliary liquidator of an insolvent ceding insurer shall give written notice to the assuming insurer of the pendency of a claim against such ceding insurer on the contract reinsured within a reasonable time after such claim is filed in the liquidation proceeding. During the pendency of such claim, any assuming insurer may investigate such claim and interpose, at its own expense, in the proceeding where such claim is to be adjudicated any defenses which it deems available to the ceding insurer, or its liquidator; and

(d) Includes a provision pursuant to Section 38a-85(g) of the General Statutes whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give such court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of such court or panel.

(Effective November 26, 1991; amended July 7, 2004)

Sec. 38a-88-11. Contracts affected

Sections 38a-88-1 to 38a-88-10, inclusive, shall apply to reinsurance agreements which have had an inception, anniversary or renewal date not less than six months after January 1, 1991, with respect to all cessions under such agreements after such inception, anniversary or renewal date.

(Effective November 26, 1991; amended July 7, 2004)

Sec. 38a-88-12. Severability

If any provision of this regulation, or the application thereof to any person or circumstance, is for any reason held to be invalid, the remainder of the regulations and the application of such provision to other persons or circumstances shall not be affected thereby.

(Effective November 26, 1991; amended July 7, 2004)

(see appendix next page)

Appendix A
FORM AR - 1
CERTIFICATE OF ASSUMING INSURER

I, _____, _____
 (name of senior officer) (title of officer)

of _____, the assuming insurer
 (name of assuming insurer)

under a reinsurance agreement(s) with one or more insurers domiciled in the State of Connecticut, hereby certify that

 (name of assuming insurer) :

1. Submits to the jurisdiction of any court of competent jurisdiction within the State of Connecticut 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. Designates the Insurance Commissioner of the State of Connecticut 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 the State of Connecticut 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 the State of Connecticut 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)

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Schedule A

Schedule B

Insider Trading of Domestic Stock Insurance Company Equity Securities

Sec. 38a-124-1. Definition of certain terms

(a) “Issuer” means any domestic stock insurance company any class of whose equity securities are subject to the provisions of sections 38a-117 to 38a-124 inclusive, of the 1965 supplement to the general statutes and are not exempt by reason of the application of either subdivision (i) or (ii) of section 38a-123.

(b) “Act” means sections 38a-117 to 38a-124 inclusive, of the 1965 supplement to the general statutes.

(c) “Officer” means a president, vice president, treasurer, actuary, secretary, controller and any other person who performs for the domestic stock insurance company functions corresponding to those performed by the foregoing officers.

(d) Subject to the disclaimer provisions of section 38a-124-19 hereof, beneficial ownership of shares includes shares registered in the name of one’s spouse, minor children or any relative resident of one’s household, and shall also include shares registered in the name of any other person if, by reason of any contract, understanding, relationship, agreement or other arrangement, one obtains therefrom benefits substantially equivalent to ownership, or can vest or re-vest title in one’s self at once or at some future time.

(Effective September 25, 1992)

Sec. 38a-124-2. Definition of securities “held of record”

(a) For the purpose of determining whether the equity securities of an issuer 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 such issuer, subject to the following conditions: (1) 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 a owner on such records if they had been maintained in accordance with accepted practice shall be included as a holder of record. (2) 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. (3) 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. (4) Securities held by two or more persons as co-owners shall be included as held of record by one person. (5) Each outstanding unregistered or bearer certificate shall be included as held of record by a separate person, except to the extent that the issuer can establish that, if such securities were registered, they would be held of record, under the provisions of this regulation, by a lesser number of persons. (6) Securities registered in substantially similar names, where the issuer has reason to believe because of the address or other indications that such names represent the same persons, may be included as held of record by one person.

(b) Notwithstanding subsection (a) of this section: (1) Securities held, to the knowledge of the issuer, 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 the issuer may rely in good faith on such information as is received in response to its request from a nonaffiliated issuer of the certificates or evidences of interest. (2) If the issuer 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.

(Effective September 25, 1992)

Sec. 38a-124-3. Transactions exempted from the operation of section 38a-119

(a) Any acquisition or disposition of any equity security by a director or officer of an issuer within six months prior to the date on which the act shall first become applicable with respect to the equity securities of such issuer shall not be subject to the operation of section 38a-119 of the 1965 supplement to the general statutes.

(b) No liability under said section 38a-119 shall be imposed on any person by reason of any purchase or sale made by him in connection with any transaction approved by the commissioner in accordance with provisions of either section 38a-152 of the general statutes or 38a-153 of the 1965 supplement thereto.

(Effective September 25, 1992)

Sec. 38a-124-4. Exemption from section 38a-119 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 38a-119 of the 1965 supplement to the general statutes, to the extent herein specified, as not comprehended within the purpose of said section, 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 issuer 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 said section 38a-119 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 said section 38a-119 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.

(Effective September 25, 1992)

Sec. 38a-124-5. Exemption from section 38a-119 of acquisitions of shares of stock and stock options under certain stock bonus, stock option and 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 the issuer of such stock or stock option shall be exempt from the operation of section 38a-119 of the 1965 supplement to the general statutes 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 issuer present, or represented, and entitled to vote at a meeting duly held in accordance with the applicable laws of this state, or (2) by the written consent of the holders of a majority of the securities of such issuer entitled to vote; provided, if such vote or written consent was not solicited substantially in accordance with the rules and regulations, if any, in effect under section 38a-147 of the 1965 supplement to the general statutes at the time of such vote or written consent, the issuer 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 the rules and regulations in effect under said section 38a-147 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 (a) the date the act first applies to such issuer or (b) 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 thirty 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 issuer. For the purposes of this subdivision, the term "issuer" includes a predecessor corporation if the plan or obligations to participate thereunder were assumed by the issuer in connection with the succession.

(b) If the selection of any director or officer of the issuer 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: (i) By the board of directors of the issuer, a majority of which board and a majority of the directors acting in the matter are disinterested persons; (ii) by, or only in accordance with the recommendation 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 (iii) otherwise in accordance with the plan, if the plan (a) 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 (b) sets forth, by formula or otherwise, effective and determinable limitations with respect to the foregoing based upon earnings of the company, 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. (2) With respect to the participation of officers who are not directors: (i)

By the board of directors of the issuer, a committee of three or more directors; or (ii) 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 subdivision, 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 issuer or any of its affiliates entitling the participants therein to acquire stock or qualified, restricted or employee stock purchase plan stock options of the company or any of its affiliates. (3) The provisions of this subdivision shall not apply with respect to any option granted, or other equity security acquired prior to the date that sections 38a-118, 38a-119 and 38a-120 of the 1965 supplement to the general statutes first became applicable with respect to any class of equity securities of any issuer.

(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 issuer, 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.

(b) All terms used in this section shall have the same meaning as in the act. In addition, for the purpose of this section, the following definitions apply: (1) "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) "Qualified stock option" and "employee stock purchase plan" shall be defined as those terms are defined in sections 422 and 423 of the Internal Revenue Code of 1954, as amended. (3) "Restricted stock option" shall be defined as that term is defined in section 424 (b) of the Internal Revenue Code of 1954, as amended; provided 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." (4) "Exercise of an option, warrant or right" shall not include (i) the making of any election to receive under any plan an award of compensation in the form of stock or credits therefor if such election is made prior to the making of the award; and if 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; if 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.

(Effective September 25, 1992)

Sec. 38a-124-6. Exemption from section 38a-119 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 issuer of such security shall be exempt from the operation of section 38a-119 of the 1965 supplement to the general statutes if: (a) The equity security is acquired by way of redemption of another security of an issuer substantially all of whose assets other than cash, or government bonds, consist of securities of the issuer of 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 issuer of the equity security acquired has recognized the applicability of subdivision (a) of this rule by appropriate corporation action.

(Effective September 25, 1992)

Sec. 38a-124-7. Exemption from section 38a-119 of certain acquisitions and dispositions of securities involving 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 38a-119 of the 1969 supplement to the general statutes 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 this section shall not apply to the extent that there shall have been either (1) a purchase of an equity security of the class deposited and a sale of any certificate representing an equity security of such class, or (2) 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 said section 38a-119, within a period of less than six months which includes the date of the deposit or withdrawal.

(Effective September 25, 1992)

Sec. 38a-124-8. Exemption from section 38a-119 of certain acquisitions and dispositions of securities pursuant to mergers or consolidations

(a) The following transactions shall be exempt from the provisions of section 38a-119 of the 1965 supplement to the general statutes as not comprehended within the purpose of said section; (1) The acquisitions of a security of an issuer, pursuant to a merger or consolidation, in exchange for a security of an issuer which, prior to said merger or consolidation, owned eighty-five per cent or more of the equity securities of all other issuers involved in the merger or consolidation except, in the case of consolidation, the resulting issuer; (2) the disposition of a security, pursuant to a merger or consolidation of an issuer which, prior to said merger or consolidation, owned eighty-five per cent or more of the equity securities of all other issuers

involved in the merger or consolidation except, in the case of consolidations, the resulting issuer; (3) the acquisition of a security of an issuer, pursuant to a merger or consolidation, in exchange for a security of an issuer which, prior to said merger or consolidation, held over eighty-five per cent of the combined assets of all the issuers 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 statement for a twelve-month period prior to the merger or consolidation; (4) the disposition of a security, pursuant to a merger or consolidation, of an issuer which, prior to said merger or consolidation, held over eighty-five per cent of the combined assets of all the issuers 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 twelve-month period prior to the merger or consolidation.

(b) A merger within the meaning of this rule shall include the sale or purchase of substantially all the assets of one issuer by another in exchange for stock which is then distributed to the security holders of the issuer 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 or otherwise, of a security in any issuer involved in the merger or consolidation and any sale, other than a sale exempted by this section or otherwise, of a security in any other issuer involved in the merger or consolidation within any period of less than six 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.

(Effective September 25, 1992)

Sec. 38a-124-9. Exemption of long term profits incident to sales within six months of the exercise of an option

(a) To the extent specified in subsection (b) of this section, the commissioner hereby exempts as not comprehended within the purposes of section 38a-119 of the 1965 supplement to the general statutes 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 to transactions specified in subsection (a) the profits inuring to the issuer 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 rule shall be deemed to enlarge the amount of profit which would inure to such company in the absence of this rule.

(c) The commissioner also hereby exempts, as not comprehended within the purposes of said section 38a-119, the disposition of a security, purchased in a transaction specified in subsection (a), pursuant to a plan or agreement for merger or consolidation, or reclassification of such issuer's securities, or for the exchange of its securities for the securities of another person which has acquired its assets, where the terms of such plan or agreement are binding upon all stockholders of the issuer 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 rule shall not apply to any transaction made unlawful by section 38-68d of said supplement 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.

(Effective September 25, 1992)

Sec. 38a-124-10. Exemption from section 38a-119 of certain acquisitions and dispositions of securities involving the conversion of similar 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 issuer's charter or other governing instruments, is convertible immediately or after a stated period of time into another equity security of the same issuer shall be exempt from the operation of section 38a-119 of the 1969 supplement to the general statutes; provided 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 an 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 said section 38a-119 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 fifteen per cent 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 operations of the terms of the security or the governing instruments.

(Effective September 25, 1992)

Sec. 38a-124-11. Exemption from section 38a-119 of certain sales of a subscription right involving the acquisition of similar securities

(a) Any sale of a subscription right to acquire any subject security of the same issuer shall be exempt from the provisions of section 38a-119 of the 1969 supplement to the general statutes to the extent prescribed in this section, as not comprehended within the purpose of said section 38a-119 if: (1) Such subscription right is acquired, directly or indirectly, from the issuer without the payment of consideration; (2) such subscription right by its terms expires within forty-five 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 issuer; and (4) a registration statement under the Securities Act of 1933, as amended, 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) As used in this section: (1) "Subscription right" means any warrant or certificate evidencing a right to subscribe to or otherwise acquire an equity security; (2) "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) "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, a sale by such person of subscription rights otherwise exempted by this section will not be so exempted to the extent of such purchase within the six-month period preceding or following such sale.

(Effective September 25, 1992)

Sec. 38a-124-12. Exemption of certain securities from section 38a-120

Any security shall be exempt from the operation of section 38a-120 of the 1965 supplement to the general statutes 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.

(Effective September 25, 1992)

Sec. 38a-124-13. Exemption from section 38a-120 of certain transactions effected in connection with a distribution

Any security shall be exempt from the operation of section 38a-120 of the 1965 supplement to the general statutes 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 said section 38a-120 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 said section 38a-120 by this rule. 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 rule.

(Effective September 25, 1992)

Sec. 38a-124-14. Exemption of sales of securities to be acquired from section 38a-120

(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 38a-120 of the 1965 supplement to the general statutes provided: (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 38a-118 of said supplement.

(b) This rule 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.

(Effective September 25, 1992)

Sec. 38a-124-15. Arbitrage transactions under section 38a-122

It shall be unlawful for any director or officer of the issuer of an equity security to effect any foreign or domestic arbitrage transaction in any equity security of such issuer, unless he includes such transaction in the statements required by section 38a-118 of the 1965 supplement to the general statutes and accounts to such issuer for the profits arising from such transaction, as provided in section 38a-119 of said supplement. The provisions of section 38a-120 of said supplement shall not apply to such arbitrage transactions. The provisions of the act 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 issuer of such security.

(Effective September 25, 1992)

Sec. 38a-124-16. Reports of directors, officers and principal stockholders. Filing of statements

(a) Initial statements of beneficial ownership of equity securities required by section 38a-118 of the 1969 supplement to the general statutes shall be filed on Form 3, which Form 3 is attached as Schedule A hereto. Statements of changes in such beneficial ownership required by that section shall be filed on Form 4, also attached as Schedule B hereto. All such statements shall be prepared and filed in accordance with the requirements of the applicable form.

(b) Any director or officer who is required to file a statement on Form 4 with respect to any change in his beneficial ownership of equity securities which occurs within six months after he became a director or officer of the issuer of such securities, or within six months after equity securities of such issuer first became subject to the provisions of the act, shall include in the first such statement the information called for by Form 4 with respect to all changes in his beneficial ownership of equity securities of such issuer which occurred within six months prior to the date of the changes which requires the filing of such statement.

(c) Any person who has ceased to be a director or officer of an issuer which has equity securities subject to the provisions of the act, or who is a director or officer of an issuer at the time it ceased to have any equity securities so subject, shall file a statement on Form 4 with respect to any change in his beneficial ownership of equity securities of such issuer which shall occur on or after the date on which he ceased to be such director or officer or the date on which the issuer ceased to have any equity securities so registered, as the case may be, if such change shall occur within six months after any change in his beneficial ownership of such securities prior to such date.

(Effective September 25, 1992)

Sec. 38a-124-17. Ownership of more than ten per cent of an equity security

(a) In determining, for the purpose of section 38a-118 of the 1969 supplement to the general statutes, whether a person is the beneficial owner, directly or indirectly, of more than ten per cent of any class of any equity security of an issuer, 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 issuer or a subsidiary of the issuer; 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 rule 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 said section 38a-118 whether a person is the beneficial owner, directly or indirectly, of more than ten per cent 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 subsection (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 subsection shall not be construed to relieve any person of any duty to comply with said section 38a-118 with respect to any equity securities consisting of options, warrants, rights or convertible securities which are otherwise subject as a class to that section.

(Effective September 25, 1992)

Sec. 38a-124-18. 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, the beneficial owner of any equity securities covered by the statement.

(Effective September 25, 1992)

Sec. 38a-124-19. Exemption from sections 38a-118 and 38a-119

(a) During the period of twelve months following their appointment and qualification, securities held by the following persons shall be exempt from sections 38a-118 and 38a-119 of the 1965 supplement to the general statutes: (1) Executors or administrators of the estate of a decedent; (2) guardians or committees for an incompetent, and (3) receivers, trustees in bankruptcy, assignees 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 twelve-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 38a-118 of said supplement and shall be liable for profits realized from trading in such securities pursuant to section 38a-119 of said supplement only when the estate being administered is a beneficial owner of more than ten per cent of any class of equity security which is an issuer subject to the act.

(c) Securities reacquired by or for the account of an issuer and held by it for its account shall be exempt from sections 38a-118 and 38a-119 of said supplement during the time they are held by the issuer.

(Effective September 25, 1992)

Sec. 38a-124-20. Exemption 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 with respect to participation by such odd-lot dealer in such transactions.

(Effective September 25, 1992)

Sec. 38a-124-21. Certain transactions subject to section 38a-118

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.

(Effective September 25, 1992)

Sec. 38a-124-22. Ownership of securities held in trust

(a) Beneficial ownership of a security for the purpose of section 38a-118 of the 1965 supplement to the general statutes shall include: (1) The ownership of securities as a trustee where 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 subsection (c) hereof, beneficial ownership of securities solely as a settlor or beneficiary of a trust shall be exempt from the provisions of said section 38a-118 where less than twenty per cent 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 said section 38a-118 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 said section 38a-118.

(c) In the event that ten per cent of any class of any equity security of an issuer 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 said section 38a-118.

(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 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 said section 38a-118 whether a person is the beneficial owner, directly or indirectly, of more than ten 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 with respect to his interest in any class of equity securities of an issuer if (i) any class of its equity securities shall be registered, or shall be required to be registered, pursuant to section 12 of the Securities Exchange Act of 1934, as amended, or (ii) such issuer shall not have any class of its equity securities held of record by one hundred or more persons on the last business day of the year next preceding the year in which equity securities of the issuer would be subject to the provisions of sections 38a-118, 38a-119 and 38a-120 of said supplement except for the existence of subsection (ii) of section 38a-123 of said supplement.

(h) Nothing in this section shall be deemed to impose any duties or liabilities with respect to reporting any transaction or holding prior to April 26, 1966.

(Effective September 25, 1992)

Sec. 38a-124-23. Exemption for small transactions

(a) Any acquisition of securities shall be exempt from section 38a-118 of the 1969 supplement to the general statutes 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 three thousand dollars 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 three thousand dollars in market value for any six months’ period, shall be exempt from said section 38a-118 and may be excluded from the computations prescribed in subdivision (2) of subsection (a) of this section.

(c) Any acquisition of securities shall be exempt from the monthly reporting requirements of said section 38a-118, provided (1) such securities are acquired pursuant to an employee stock purchase plan in which the officer is a participant and which has a maximum permissible payroll deduction of not more than one hundred dollars a month, (2) all securities acquired in any calendar year pursuant to such plan are reported under said section 38a-118 not later than ten days following the close of such calendar year and (3) any other reports filed under said section 38a-118 shall have an appropriate footnote stating that shares acquired under such employee stock purchase plan have not been included in such report since they are to be reported on an annual basis.

(d) Any person exempted by subsection (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.

(Effective September 25, 1992)

Sec. 38a-124-24. Exemption from section 38a-119 of transactions which need not be reported under section 38a-118

Any transaction which has been or shall be exempted by the commissioner from the requirements of section 38a-118 of the 1965 supplement to the general statutes shall, insofar as it is otherwise subject to the provisions of section 38a-119 of said supplement, be likewise exempted from said section 38a-119.

SCHEDULE A

CONNECTICUT INSURANCE DEPARTMENT

Hartford, Connecticut

CONNECTICUT

FORM 3

INITIAL STATEMENT OF BENEFICIAL OWNERSHIP OF SECURITIES

Filed Pursuant to Section 38a-118 of the Connecticut General Statutes

(Name of domestic stock insurance company)

(Name of person whose ownership is reported)

(Business address of such person; street, city, zone, State)

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

Date of event which requires the filing of this statement: (See instruction 5) _____

(continued)

SECURITIES BENEFICIALLY OWNED (See instruction 7)

TITLE OF SECURITY (See instruction 8)	NATURE OF OWNERSHIP (See instruction 9)	AMOUNT OWED beneficially (See instruction 10)

REMARKS:

(Signature)

Date of statement

SCHEDULE A
CONNECTICUT INSURANCE DEPARTMENT

Hartford, Connecticut

CONNECTICUT

FORM 3

INITIAL STATEMENT OF BENEFICIAL OWNERSHIP OF SECURITIES

Filed Pursuant to Section 38a-118 of the Connecticut General Statutes

INSTRUCTIONS

1. PERSONS REQUIRED TO FILE STATEMENTS.

A statement on this form is required to be filed by every person who on December 31, 1965, (i) is directly or indirectly the beneficial owner of more than 10 per cent of any class of any equity security of a Connecticut domiciled stock insurance company, or (ii) is an officer, as defined by the Connecticut Insurance Commissioner, or a director of the company which is the issuer of such securities; and every person who thereafter becomes such a beneficial owner, director or officer. However, such reporting requirements shall not apply with respect to any equity securities of a domestic stock insurance company if (i) any class of its equity securities shall be registered, or shall be required to be registered, pursuant to Section 12 of the Securities Exchange Act of 1934, as amended, or (ii) such domestic stock insurance company shall not have any class of its equity securities held of record by one hundred or more persons on the last business day of the year next preceding the year in which equity securities of the company would be subject to the provisions of Sections 38a-118, 38a-119 and 38a-120 except for the provisions of subdivision (ii) of Section 38a-123.

2. WHEN STATEMENTS ARE TO BE FILED.

(a) Persons who hold any of the relationships specified in Instruction 1 on December 31, 1965, are required to file a statement within 10 days after December 31, 1965. Persons who subsequently assume any of the specified relationships are required to file a statement within 10 days after assuming such relationship.

(b) Statements are not deemed to have been filed with the Commissioner until they have actually been received by the Commissioner.

3. WHERE STATEMENTS ARE TO BE FILED.

One signed copy of each statement shall be filed with the Connecticut Insurance Commissioner, State Office Building, Hartford, Connecticut.

4. SEPARATE STATEMENT FOR EACH COMPANY.

A separate statement shall be filed with respect to the securities of each company.

5. RELATIONSHIP OF REPORTING PERSON TO COMPANY.

Indicate clearly the relationship of the reporting person to the company, for example, "Director," "Director and Vice President," "Beneficial owner of more than 10 per cent of the company's common stock," etc.

6. DATE AS OF WHICH BENEFICIAL OWNERSHIP IS TO BE GIVEN.

The information as to beneficial ownership of securities shall be given as of the date on which the event occurred which requires the filing of a statement on this form; for example, when the person whose ownership is reported became a director or officer of the company.

7. CLASSES OF SECURITIES TO BE REPORTED.

Persons specified in Instruction 1 above shall include information as to their beneficial ownership of all classes of equity securities of the domestic stock insurance company.

8. TITLE OF SECURITY.

The statement of the title of a security shall be such as clearly to identify the security even though there may be only one class, for example, "Class A Common Stock," "\$6 Convertible Preferred Stock," "5% Debentures Due 1965," etc.

9. NATURE OF OWNERSHIP.

Under "Nature of ownership," state whether ownership of the securities is "direct" or "indirect." If the ownership is indirect, i.e., through a partnership, corporation, trust or other entity, indicate, in a footnote or other appropriate manner, the name or identity of the medium through which the securities are indirectly owned. The fact that securities are held in the name of a broker or other nominee does not, of itself, constitute indirect ownership. Securities owned indirectly shall be reported on separate lines from those owned directly and also from those owned through a different type of indirect ownership.

10. STATEMENT OF AMOUNT OWNED.

In stating the amount of securities beneficially owned, give the face amount of debt securities or the number of shares or other units of other securities. In the case of securities owned indirectly, the entire amount of securities owned by the partnership, corporation, trust or other entity, shall be stated. The person whose ownership is reported may, if he so desires, also indicate, in a footnote or other appropriate manner, the extent of his interest in the partnership, corporation, trust or other entity.

11. INCLUSION OF ADDITIONAL INFORMATION.

A statement may include any additional information or explanation deemed relevant by the person filing the statement.

12. SIGNATURE.

If the statement is filed for a corporation, partnership, trust, etc., the name of the organization shall appear over the signature of the officer or other person authorized to sign the statement. If the statement is filed for an individual, it shall be signed by him or specifically on his behalf by a person authorized to sign for him.

SCHEDULE B

CONNECTICUT INSURANCE DEPARTMENT

Hartford, Connecticut

CONNECTICUT

FORM 4

STATEMENT OF CHANGES IN BENEFICIAL OWNERSHIP OF SECURITIES

Filed Pursuant to Section 38a-118 of the Connecticut General Statutes

(Name of domestic stock insurance company)

(Name of person whose ownership is reported)

(Business address of such person; street, city, zone, State)

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

Statement for Calendar Month of _____, 19____

(continued)

CHANGES IN 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 disposed of (See instruction 9)	NATURE OF OWNERSHIP (See instruction 10)	AMOUNT OWNED beneficially at end of month (See instruction 9)

REMARKS: (See instruction 11)

(Signature)

Date of statement

SCHEDULE B**CONNECTICUT INSURANCE DEPARTMENT**

Hartford, Connecticut

CONNECTICUT**FORM 4****STATEMENT OF CHANGES IN BENEFICIAL OWNERSHIP OF SECURITIES****Filed Pursuant to Section 38a-118 of the Connecticut General Statutes****INSTRUCTIONS****1. PERSONS REQUIRED TO FILE STATEMENTS.**

Statements on this form are required to be filed by every person who at any time during any calendar month was (i) directly or indirectly the beneficial owner of more than 10 per cent of any class of equity securities of a Connecticut domiciled stock insurance company, or (ii) an officer, as defined by the Connecticut Insurance Commissioner, or a director of the company which is the issuer of such securities, and who during such month had any change in his beneficial ownership of any class of equity securities of such company. However, such reporting requirements shall not apply with respect to any equity securities of a domestic stock insurance company if (i) any class of its equity securities shall be registered, or shall be required to be registered, pursuant to Section 12 of the Securities Exchange Act of 1934, as amended, or (ii) such domestic stock insurance company shall not have any class of its equity securities held of record by one hundred or more persons on the last business day of the year next preceding the year in which equity securities of the company would be subject to the provisions of Section 38a-118, 38a-119 and 38a-120, except for the provisions of subdivision (ii) of Section 38a-123.

2. WHEN STATEMENTS ARE TO BE FILED.

Statements are required to be filed on or before the 10th day after the end of each month in which any change in beneficial ownership has occurred. Statements are not deemed to have been filed with the Commissioner until they have actually been received by the Commissioner.

3. WHERE STATEMENTS ARE TO BE FILED.

One signed copy of each statement shall be filed with the Connecticut Insurance Commissioner, State Office Building, Hartford, Connecticut.

4. SEPARATE STATEMENT FOR EACH COMPANY.

A separate statement shall be filed with respect to the securities of each company.

5. RELATIONSHIP OF REPORTING PERSON TO COMPANY.

Indicate clearly the relationship of the reporting person to the company; for example, "Director," "Director and Vice President," "Beneficial owner of more than 10 per cent of the company's common stock," etc.

6. TRANSACTIONS AND HOLDINGS TO BE REPORTED.

(a) Persons required to file statements on this form shall include in their statements all changes during the month in their beneficial ownership, and their beneficial ownership at the end of the month, of all classes of equity securities of the company.

(b) Every transaction shall be reported even though purchases and sales during the month are equal or the change involves only the nature of ownership, for example, from direct to indirect ownership. Beneficial ownership at the end of the month of all classes of securities required to be reported shall be shown even though there has been no change during the month in the ownership of securities of one or more classes.

7. TITLE OF SECURITY.

The statement of the title of the security shall be such as clearly to identify the security even though there may be only one class, for example, "Class A Common Stock," "\$6 Convertible Preferred Stock," "5% Debentures Due 1965," etc.

8. DATE OF TRANSACTION.

The exact date (month, day and year) of each transaction shall be stated opposite the amount involved in the transaction.

9. STATEMENT OF AMOUNTS OF SECURITIES.

In stating the amount of securities acquired, disposed of, or beneficially owned, give the face amount of debt securities or the number of shares or other units of other securities. In the case of securities owned indirectly, i.e., through a partnership, corporation, trust or other entity, the entire amount of securities involved in the transaction or owned by the partnership, corporation, trust or other entity shall be stated. The person whose ownership is reported may, if he so desires, also indicate, in a footnote or other appropriate manner, the extent of his interest in the transactions or holdings of the partnership, corporation, trust or other entity.

10. NATURE OF OWNERSHIP.

Under "Nature of ownership," state whether ownership of the securities is "direct" or "indirect." If the ownership is indirect, i.e., through a partnership, corporation, trust or other entity, indicate, in a footnote or other appropriate manner, the name or identity of the medium through which the securities are indirectly owned. The fact that securities are held in the name of a broker or other nominee does not, of itself, constitute indirect ownership. Securities owned indirectly shall be reported on separate lines from those owned directly and from those owned through a different type of indirect ownership.

11. CHARACTER OF TRANSACTION.

If the transaction was with the issuer of the securities, so state. If it involved the purchase of securities through the exercise of options, so state and give the exercise price per share. If any other purchase or sale was effected otherwise than in the open market, that fact shall be indicated. If the transaction was not a purchase or

sale, indicate its character; for example, gift, 5% stock dividend, etc., as the case may be. The foregoing information may be appropriately set forth in the table or under “Remarks” at the end of the table.

12. INCLUSION OF ADDITIONAL INFORMATION.

Statements may contain any additional information or explanation deemed relevant by the person filing the statement.

13. SIGNATURE.

If the statement is filed for a corporation, partnership, trust, etc., the name of the organization shall appear over the signature of the officer or other person authorized to sign the statement. If the statement is filed for an individual, it shall be signed by him or specifically on his behalf by a person authorized to sign for him.

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Insurance Holding Company Act

Sec. 38a-138-1. Forms — general requirements

(a) Sections 38a-138-1 to 38a-138-16, inclusive, and the forms prescribed in the Appendixes A, B, C and D, are intended to implement the provisions of the Connecticut Insurance Holding Company System Regulatory Act, Sections 38a-129 to 38a-140, inclusive, of the General Statutes. Appendix A contains “Form A” (Statement Regarding the Acquisition of Control of or Merger With a Domestic Insurer); Appendix B contains “Form B” (Insurance Holding Company System Annual Registration Statement); Appendix C contains “Form C” (Summary of Registration Statement); and Appendix D contains “Form D” (Prior Notice of a Transaction). These forms are intended to be guides in the preparation of the statements required by Sections 38a-130, 38a-135, and 38a-136 of the General Statutes; they are not intended to be blank forms which are to be filled in. Each form, when filed, shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, 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.

(b) Four (4) complete copies of Form A statements including exhibits and all other papers and documents filed as a part thereof, and one (1) complete copy of Forms B, C and D including exhibits and all other papers and document filed as a part thereof, shall be filed with the Commissioner by personal delivery addressed to:

State of Connecticut Insurance Department
153 Market Street (11th Floor)
Hartford, CT 06103
Attention: Examination Division

or, by U.S. mail addressed to:

State of Connecticut, Insurance Department
P.O. Box 816
Hartford, CT 06142-0816
Attn: Examination Division

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, in which case the insurer has ten (10) days from receipt of the notice to file such form. At least one of the copies shall be manually signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of such power of attorney or other authority shall also be filed with the statement.

(c) Statements should be prepared on paper $8\frac{1}{2}'' \times 11''$ (or $8\frac{1}{2}'' \times 14''$) in size and preferably bound at the top or the top left-hand corner. Exhibits and financial statements, unless specifically prepared for the filing, may be submitted in their original size. All copies of any statement, financial statements, or exhibits 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. Statements shall be in the English language and monetary

values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into United States currency.

(Effective July 26, 1993)

Sec. 38a-138-2. Forms — incorporation by reference, summaries and omissions

(a) Information required by any item of Form A, Form B or Form D may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of Form A, Form B or Form D provided such document or paper is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. Documents currently on file with the Commissioner which were filed within three years of the filing of the present documents need not be attached as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Matter shall not be incorporated by reference in any case where such incorporation would render the statement incomplete, unclear or confusing.

(b) Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to such statement, the summary or outline may incorporate by reference particular parts of any exhibit or document currently on file with the Commissioner which was filed within three years and may be qualified in its entirety by such reference. In any case where two or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the dates of execution, or other details, a copy of only one of such documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which such documents differ from the documents a copy of which is filed.

(Effective July 26, 1993)

Sec. 38a-138-3. Forms — information unknown or unavailable and extension of time to furnish

(a) 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; and

(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.

(b) 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 a separate document:

(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 request for extension shall be deemed granted unless the Commissioner within thirty (30) days after receipt thereof enters an order denying the request.

(Effective July 26, 1993)

Sec. 38a-138-4. Forms — additional information and exhibits

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 statement. Such exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Amendments to Forms A, B, C or D shall include on the top of the cover page the phrase: “Amendment No. (insert number) to” and shall indicate the date of the amendment and not the date of the original filing.

(Effective July 26, 1993)

Sec. 38a-138-5. Definitions

As used in Sections 38a-138-1 to 38a-138-16, inclusive:

(a) “Commissioner” means the Insurance Commissioner of the State of Connecticut.

(b) “Executive officer” means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.

(c) “Foreign insurer” shall include an alien insurer except where clearly noted otherwise.

(d) “Ultimate controlling person” means that person which is not controlled by any other person.

(e) Unless the context otherwise requires, other terms found in these regulations are used as defined in Section 38a-129 of the General Statutes.

(Effective July 26, 1993)

Sec. 38a-138-6. Acquisition of control — statement filing; amendments to form A; hearing

A person required to file a statement pursuant to Sec. 38a-130 of the General Statutes shall furnish the required information on Form A (Appendix A of this regulation). The applicant shall promptly advise the Commissioner of any changes in the information so furnished on Form A arising subsequent to the date upon which such information was filed with the Commissioner. The Commissioner shall hold a public hearing within thirty (30) days from the date at which the Commissioner determines that the Form A is complete in all respects. If any amendments to the Form A is filed after such a determination has been made by the Commissioner, the hearing date may be postponed by the Commissioner for a reasonable period not to exceed thirty (30) days after the filing of such amendment.

(Effective July 26, 1993)

Sec. 38a-138-7. Acquisition under subdivision (1) of subsection (c) of section 38a-130

If a person seeks to effectuate an acquisition of control of, or merger with, any corporation which is not itself a domestic insurance company but which controls a

domestic insurance company, the name of the domestic insurer on the cover page of Form A should be indicated as follows:

“ABC Insurance Company, a subsidiary of XYZ Holding Company,” and references to “the insurer” contained in Form A shall refer to both the domestic insurance company and to the corporation which controls the domestic insurance company.

(Effective July 26, 1993)

Sec. 38a-138-8. Annual registration of insurers — statement filing

An insurer required to file an annual registration statement pursuant to Section 38a-135 of the General Statutes shall furnish the required information on Form B (Appendix B of this regulation).

(Effective July 26, 1993)

Sec. 38a-138-9. Summary of registration — statement filing

An insurer required to file an annual registration statement pursuant to Section 38a-135 of the General Statutes is also required to furnish information required on Form C (Appendix C of this regulation). An insurer shall file a copy of Form C in each state in which the insurer is authorized to do business, if requested by the Commissioner of that state.

(Effective July 26, 1993)

Sec. 38a-138-10. Amendments to form B

(a) An amendment to Form B shall be filed within 15 days after the end of any month in which there is a material change to the information provided in the annual registration statement.

(b) Amendments shall be filed in the Form B format with only those items which are being amended reported. Each such amendment shall include at the top of the cover page “Amendment No. (insert number) to Form B for (insert year)” and shall indicate the date of the change and not the date of the original filings.

(Effective July 26, 1993)

Sec. 38a-138-11. Alternative and consolidated registrations

(a) Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register under Section 38a-135 of the General Statutes. A registration statement may include information not required by the Act 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.

(b) 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 brief 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.

(c) With the prior approval of the Commissioner, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under subsection (a) above.

(d) Any insurer may take advantage of the provisions of subsection (h) or (i) of section 38a-135 of the General Statutes without obtaining the prior approval of the Commissioner. The Commissioner, however, reserves the right to require individual filings if he deems such filings necessary in the interest of clarity, ease of administration or the public good.

(Effective July 26, 1993)

Sec. 38a-138-12. Disclaimers and termination of registration

(a) 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 such 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 such person should not be considered to control the subject; and

(5) Such additional information as the Commissioner may require to effectuate the purpose of the Connecticut Insurance Holding Company Act.

(b) A request for termination of registration shall be deemed to have been granted unless the Commissioner, within 30 days after he receives the request, notifies the registrant otherwise.

(Effective July 26, 1993)

Sec. 38a-138-13. Transactions subject to prior notice — notice filing

An insurer required to give notice of a proposed transaction pursuant to Section 38a-136 of the General Statutes shall furnish the required information on Form D (Appendix D of this regulation).

(Effective July 26, 1993)

Sec. 38a-138-14. Extraordinary dividends and other distributions

(a) Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:

(1) The amount of the proposed dividend;

(2) The date established for payment of the dividend;

(3) 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;

(4) A copy of the calculations determining that the proposed dividend is extraordinary. The work paper shall include the following information:

(i) The amounts, dates and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurers own securities) paid within the period of 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.

(ii) Surplus as regards policyholders (total capital and surplus) as of the 31st day of December next preceding;

(iii) If the insurer is a life insurer, the net gain from operations for the 12-month period ending the 31st day of December next preceding;

(iv) If the insurer is not a life insurer, the net income less realized capital gains for the 12-month period ending the 31st day of December next preceding and the two preceding 12-months periods; and

(v) If the insurer is not a life insurer, the dividends paid to stockholders excluding distributions of the insurer's own securities in the preceding two calendar years.

(5) The insurer's most recent annual or quarterly balance sheet and statement of income filed pursuant to Section 38a-53, a statement as to whether there has been a material change in the financial condition of the insurer since such financial report was filed with the Commissioner; and

(6) 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.

(b) Subject to subsection (f) of Section 38a-136 of the General Statutes, each registered insurer shall report to the Commissioner all dividends and other distributions to shareholders within 15 business days following the declaration thereof, including the same information required by subsections (a) (4) (i)-(v).

(Effective July 26, 1993)

Sec. 38a-138-15. Adequacy of surplus

The factors set forth in subsection (g) of section 38a-136 of the General Statutes are not intended to be an exhaustive list. In determining the adequacy and reasonableness of an insurer's surplus no single factor is necessarily 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 shall 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 shall consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.

(Effective July 26, 1993)

Sec. 38a-138-16. Severability

If any provision of these regulations, or the application thereof to any person or circumstance is held invalid, such determination shall not affect other provisions or applications of these regulations which can be given effect without the invalid provision or application, and to that end the provisions of these regulations are severable.

APPENDIX A

Form A

**Statement Regarding the Acquisition
of Control of or Merger With A Domestic Insurer**

Name of Domestic Insurer

BY

Name of Acquiring Person (Applicant)

Filed with the Insurance Department of

(State of domicile of insurer being acquired)

Dated: _____, 19____

Name, Title, address and telephone number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

Item 1. Insurer and Method of Acquisition

State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired or the merger effected.

Item 2. Identity and Background of the Applicant

(a) State the name and address of the applicant seeking to acquire control over or to effect a merger with the insurer.

(b) If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant’s affiliates.

(c) Furnish a chart or listing clearly presenting the identities of the inter-relationships among the applicant and all affiliates of the applicant. No affiliate need be identified if its total assets are equal to less than 1/2 of 1% of the total assets of the ultimate controlling person affiliated with the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant 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 involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.

Item 3. Identity and Background of Individuals Associated With the Applicant

State the following with respect to (1) the applicant if (s)he is an individual or (2) all persons who are directors, trustees, executive officers or owners, beneficial or otherwise, of 10% or more of the voting securities of the applicant if the applicant is not an individual.

(a) Name and business address;

(b) 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;

(c) Material occupations, positions, offices or employment during the last five years, giving the starting and ending dates of each and the name, principal business and address of any business 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 governmental 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.

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

(e) Whether or not, during the last ten years, such person has been the subject of any proceeding under the Federal Bankruptcy Code, (or in the case of an alien person, such equivalent provision) or whether or not, during the ten year period, any business or organization in which such person was a director, officer, trustee, partner, owner, manager or other official has been subject to any such proceeding, (or in the case of an alien person or such equivalent provision) either during the time in which such person was a director, officer or trustee, if a corporation, or a partner, owner, manager, joint venturer, or the official, if not a corporation, or within twelve months thereafter;

(f) Whether or not, during the ten year period, such person has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law or in the case of an alien person, applicable law regulating the business of insurance, securities, or banking, together with details as to any such event; and

(g) A complete credit report on such person prepared by an independent credit rating agency acceptable to the Commissioner.

Item 4. Nature, Source and Amount of Consideration

(a) Describe the nature, source and amount of funds or other considerations used or to be used in effecting the merger or other 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 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, including any pledge of the insurance company's stock or the stock of any of its subsidiaries or affiliates, 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 applicant wishes the identity of the lender to remain confidential, he must specifically request that the identity be kept confidential.

Item 5. Future Plans of Insurer

Describe any plans or proposals which the applicant may have to declare an extraordinary dividend or make other distributions, to liquidate such insurer, to sell its assets to or merge or consolidate it with any person or persons or to make any other material change in its business operations or corporate structure or management or to cause the insurer to enter into material contracts, agreements, arrangements, understandings or transactions of any kind with any party. In addition, describe any plans or proposals of the applicant or any of its affiliates, including any plans or proposals for ownership or control of any of the insurer's affiliates, which may have a material effect on the insurer.

Item 6. Voting Securities to be Acquired

State the number of shares of the insurer's voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer,

request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at, including but not limited to, a certification by any consultant, accountant, financial advisor or other expert, used by such person, as to the accuracy and fairness of the method.

Item 7. Ownership of Voting Securities

State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates or any person listed in Item 3, including any security convertible into a right to acquire a voting security whether or not such right or conversion or acquisition is exercisable immediately or at some future time.

Item 8. Contracts, Arrangements, or Understandings With Respect to Voting Securities of the Insurer

Give a full description of any contracts, arrangements or understandings, whether oral or in writing, with respect to any voting security of the insurer or any security convertible into or evidencing a right to acquire a voting security whether or not such right of conversion or acquisition is exercisable immediately or at some future time, in which the applicant, its affiliates or any person 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. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into. A copy of any such written contracts, agreements, arrangements or understandings shall be provided to the Commissioner.

Item 9. Recent Purchases of Voting Securities

Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this Statement. Include in such description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any such shares so purchased are hypothecated and, if hypothecated, describe the terms of such arrangement.

Item 10. Recent Recommendations to Purchase

Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates or any person listed in Item 3 during the 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 insurer for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

Item 12. 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 fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar unaudited financial information covering the period from

the end of such person's last fiscal year, if such information is available. Such 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 applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant 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, unaudited financial information shall be accompanied by a affidavit or certification of the chief financial officer of the acquiring party that (1) such unaudited financial statement is true and correct, as of its date, and (2) there has been no material change in the financial statements to the dated of the affidavit or certification. If the applicant 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 the 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 insurer and (if distributed) of additional soliciting material relating thereto, any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by Form A or Sections 38a-138-1 and 38a-138-3.

Item 13. Other Information

(a) Attach copies of any regulatory filings of any acquiring party in connection with the proposed acquisition of control or merger including, but not limited to, filings with the Securities and Exchange Commission, the United States Department of Justice, or any other Federal or State regulatory body or commission.

(b) Provide an analysis of the competitive impact in the State of Connecticut on each line of insurance listed in the annual statements of the insurer affected by such acquisition.

(c) Provide such additional information as the Commissioner may prescribe as necessary or appropriate for the protection of policyholders of the insurance company or in the public interest.

Item 14. Signature and Certification

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 38a-130 of the Connecticut General Statutes, _____ has caused this application 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 (s)he has duly executed the attached application dated _____, 19_____, for and on behalf of _____; that (s)he is the _____ of such company
(Name of Applicant) (Title of Officer)
and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)_____

(Type or print name beneath)_____

**Form B
Insurance Holding Company System Annual Registration Statement**

Filed with the Insurance Department of the State of _____

By

Name of Registrant

On Behalf of 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:

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 equal to less than one-half of one per cent of the total assets of the ultimate controlling person within the insurance holding company system. 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:

- (a) Name.
- (b) Home office address.
- (c) Principal executive office address.
- (d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.
- (e) The principal business of the person.
- (f) The name and address of any person who holds or owns 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.
- (g) If court proceedings involving 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 information for the directors and executive officers of the ultimate controlling person: the individual's name and address, his or her principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past ten years.

Item 5. Transactions and Agreements

Briefly describe the following agreements in force, 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) management agreements, service contracts and cost-sharing arrangements;
- (6) reinsurance agreements;
- (7) dividends and other distributions to shareholders;
- (8) consolidated tax allocation agreements; and
- (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.

No information need be disclosed if such information is not material for purposes of Section 38a-135 of the General Statutes.

Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of 1% or less of the Registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include at least the following: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to such transaction, and relationship of the affiliated parties to the Registrant.

Item 6. Litigation or Administrative Proceedings

A brief description of any litigation or administrative proceedings of the following types, either then 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; give the names of the parties and the court or agency in which such litigation or proceeding is or was pending:

(a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which in the opinion of management may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

Item 7. Statement Regarding Plan or Series of Transactions

The insurer 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, 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 in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial 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 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 reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person;

and any additional documents or papers required by Form B or Sections 38a-138-1 and 38a-138-3.

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 required as follows:

SIGNATURE

Pursuant to the requirements of Section 38a-135 of the Connecticut General Statutes, the Registrant has caused this annual registration statement to be 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 (s)he has duly executed the attached annual registration statement dated _____, 19____, for and on behalf of _____; that (s)he is the _____

(Name of Company)

(Title of Officer)

of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

APPENDIX C

Form C

Summary of Registration Statement

Filed with the Insurance Department of the State of _____

By

Name of Registrant

On Behalf of 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:

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.

Changes occurring under Item 2 of Form B insofar as changes in the percentage of each class of voting securities held by each affiliate is concerned, need only be included where such changes are ones which result in ownership or holdings of 10 percent or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

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 named president of the ultimate controlling person.

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.

The insurer 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.

SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 38a-135 of the Connecticut General Statutes, the Registrant has caused this summary of registration statement to be 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 (s)he has duly executed the attached summary of registration statement dated _____, 19____, for and on behalf of _____; that (s)he is the _____

(Name of Company)

(Title of Officer)

of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)

(Type or print name beneath)

APPENDIX D

Form D

Prior Notice of a Transaction

Filed with the Insurance Department of the State of _____

By

Name of Registrant

On Behalf of 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:

Item 1. Identity of Parties to Transaction

Furnish the following information for each of the parties to the transaction:

- (a) Name.
- (b) Home office address.
- (c) Principal executive office address.

(d) The organizational structure, i.e. corporation, partnership, individual, trust, etc.

(e) A description of the nature of the parties' business operations.

(f) 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.

(g) Where the transaction is with a non-affiliate, the name(s) of the affiliate(s) 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:

(a) A statement as to whether notice is being given under Section 38a-136 (b) (1), (2), (3), (4), or (5) of the General Statutes.

(b) A statement of the nature of the transaction.

(c) The proposed effective date of the transaction.

Item 3. Sales, Purchases, Exchanges, Loans, Extensions of Credit, Guarantees or Investments

For each transaction for which notice is being given, 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 purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice, and 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 consideration other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

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.

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.

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, (a) in the case of non-life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as regards policyholders or, (b) in the case of life insurers, 3% of the insurer's admitted assets, each as of the 31st day of December next preceding.

Item 4. Loans or Extensions of Credit to a Non-affiliate

If notice is required and 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.

No notice need be given if the loan or extension of credit is one which equals less than, in the case of non-life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as regards policyholders or, with respect to life insurers, 3% of the insurer's admitted assets, each as of the 31st day of December next preceding.

Item 5. Reinsurance

If the transaction is a reinsurance agreement or modification thereto, as described by Section 38a-136 (b) (3) of the General Statutes, furnish a description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year, 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 non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one 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.

No notice need be given for reinsurance agreements or modifications thereto if the reinsurance premium or a change in the insurer's liabilities in connection with the reinsurance agreement or modification thereto is less than 5% of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding.

Item 6. Management Agreements, Service Agreements and Cost-Sharing Arrangements

For material management and service agreements, furnish:

- (a) a brief description of the managerial responsibilities, or services to be performed.
- (b) a brief description of the agreement, 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.

For material cost-sharing arrangements, furnish:

- (a) a brief description of the purpose of the agreement.
- (b) a description of the period of time during which the agreement is to be in effect.
- (c) a brief description of each party's expenses or costs covered by the agreement.
- (d) 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 Section 38a-136 of the Connecticut General Statutes, _____ has caused this notice 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 (s)he has duly executed the attached notice dated _____, 19____, for and on behalf of _____;
(Name of Applicant)
that (s)he is the _____ of such company and that (s)he is
(Title of Officer)
authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____
(Type or print name beneath) _____
(Effective July 26, 1993)

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Proxies, Consents and Authorizations of Domestic Stock Insurers

Sec. 38a-147-1. Application

This regulation is applicable to each domestic stock insurer which has any class of equity security held of record by one hundred or more persons; provided this regulation shall not apply to any insurer if ninety-five per cent or more of its equity securities is 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 the jurisdiction of said commission.

(Effective September 25, 1992)

Sec. 38a-147-2. Proxies, consents and authorizations

No domestic stock insurer, or any director, officer or employee of such insurer subject to section 38a-147-1, 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 hereto annexed and hereby made a part of this regulation.

(Effective September 25, 1992)

Sec. 38a-147-3. Information statement

Unless proxies, consents or authorizations in respect of any class of equity security of a domestic insurer subject to section 38a-147-1 are solicited by or on behalf of the management of such insurer from the holders of record of such security prior to any annual or other meeting of such security holders, such insurer shall, in accordance with this regulation and the schedule thereunder, file with the insurance commissioner, hereafter referred to as 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 (d) of section 38a-147-5 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, except that, in the case of a class of securities in unregistered or bearer form, such statement need be transmitted only to those security holders whose names and addresses are known to the insurer.

(Effective September 25, 1992)

Sec. 38a-147-4. Definitions

(a) The definitions and instructions set out in Schedule SIS, as promulgated by the National Association of Insurance Commissioners, attached as Exhibit 1 hereto, shall be applicable for purposes of this regulation.

(b) The terms "solicit" and "solicitation" for purposes of this regulation shall include: (1) Any request for a proxy, whether or not accompanied by or included in a form of proxy; or (2) any request to execute or not to execute, or to revoke, a proxy; or (3) the furnishing of a proxy or other communication to stockholders under circumstances reasonably calculated to result in the procurement, withholding or revocation of a proxy.

(c) The terms “solicit” and “solicitation” shall not include: (1) Any solicitation by a person in respect of securities of which he is the beneficial owner; (2) 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 company, 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, the beneficial owner desires 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; (3) 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.

(d) The term “equity security” shall have the same meaning given to it in section 38a-117 of the general statutes.

(Effective September 25, 1992)

Sec. 38a-147-5. Information furnished to security holders

(a) No solicitation subject to this regulation 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.

(b) 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 (a) 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 years 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.

(c) 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 (a) of section 38a-147-7, whichever date is later.

(d) 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 38a-147-3, containing the information called for by all of the items of Schedule A, 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 (b) hereof.

(Effective September 25, 1992)

Sec. 38a-147-6. Requirements of proxy

(a) The form of proxy (1) shall indicate in bold-faced type whether or not the proxy is solicited on behalf of the management, (2) shall provide a specifically designated blank space for dating the proxy and (3) 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 (c) hereof.

(b) (1) Means shall be provided in the 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-faced type how it is intended to vote the shares or authorization represented by the proxy in each such case.

(2) 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 shall so state in bold-faced type.

(c) A 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.

(d) No proxy shall confer authority (1) 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 (2) 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.

(e) The proxy statement or form of proxy shall provide, subject to reasonable specified conditions, that the proxy will be voted and that, where the person solicited specifies by means of ballot provided pursuant to subsection (b) hereof a choice with respect to any matter to be acted upon, the vote will be in accordance with the specifications so made.

(f) 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.

(Effective September 25, 1992)

Sec. 38a-147-7. Material to be filed

(a) Two preliminary copies of 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.

(b) 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.

(c) Two definitive copies of 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.

(d) Where any proxy statement, form of proxy or other material filed pursuant to these rules is amended or revised, two of the copies shall be marked to clearly show such changes.

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

(f) Notwithstanding the provisions of subsections (a) and (b) hereof and of subsection (e) of section 38a-147-10, 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 (c) hereof not later than the date such material is used or published. The provisions of subsections (a) and (b) hereof and subsection (e) of section 38a-147-10 shall apply, however, to any reprints or reproductions of all or any part of such material.

(Effective September 25, 1992)

Sec. 38a-147-8. 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.

(Effective September 25, 1992)

Sec. 38a-147-9. Exclusion

No person making a solicitation which is subject to this regulation 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.

(Effective September 25, 1992)

Sec. 38a-147-10. Special provisions

(a) This section shall apply to any solicitation subject to this regulation 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.

(b) (1) For purposes of this section the terms “participant” and “participant in a solicitation” include: (A) The insurer; (B) any director of the insurer, and any nominee for whose election as a director proxies are solicited; (C) any other person, acting alone or with one or more other persons, committees or groups, in organizing, directing or financing the solicitation. (2) For the purposes of this section the terms “participant” and “participant in a solicitation” do not include: (A) 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; (B) 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; (C) 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; (D) 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 (E) 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.

(c) (1) 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 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. (2) 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. (3) 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 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. (4) If, subsequent to the filing of the statements required by subdivisions (1), (2) and (3) of this subsection, additional persons become participants in a solicitation subject to this regulation, 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, 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. (5) 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. (6) Each statement and amendment thereto filed pursuant to this subsection shall be part of the public files of the commissioner.

(d) Notwithstanding the provisions of subsection (a) of section 38a-147-5, 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 with respect to such solicitation, provided (1) the statements required by subsection (c) hereof are filed by or on behalf of each participant in such solicitation; (2) no form of proxy is furnished to security holders prior to the time the written proxy statement required by subsection (a) of section 38a-147-5 is furnished to such persons; provided this subdivision (2) shall not apply where a proxy statement then meeting the requirements of Schedule A has been furnished to security holders; (3) at least the information specified in subdivisions (2) and (3) of the statements required by subsection (c) 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; (4) a written proxy statement containing the

information specified in Schedule A with respect to a solicitation is sent or given security holders at the earliest practicable date.

(e) 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 (a) of section 38a-147-5 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.

(f) Notwithstanding the provisions of subsections (b) and (c) of section 38a-147-5, two copies of any portion of the report referred to in subsection (b) of section 38a-147-5 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. 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.

(Effective September 25, 1992)

Schedule A

Information Required in Proxy Statement

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.

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 a charter amendment, or other similar act, state whether the person solicited will be notified of such date.

3. Persons making solicitations not subject to section 38a-147-10. (a) 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.

(b) 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.

(c) If the solicitation is to be made by specially engaged employees or paid solicitors, state (1) the material features of any contract or arrangement for such solicitation and identify the parties, and (2) the cost or anticipated cost thereof.

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 for 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.

5. Voting securities and principal holders thereof. (a) 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.

(b) 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.

(c) 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.

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 a vote of security holders at a meeting for which proxies were solicited under this regulation.

(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.

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 (1) the election of directors, (2) any remuneration plan, contract or arrangement in which any director, nominee for election as a director, or officer of the insurer will participate, (3) any pension or retirement plan in which any such person will participate, or (4) 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.

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 7 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 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.

9. Pension and retirement plan. 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 payments to be made for the benefit of (a) each person named in item 7 of this schedule, (b) directors and officers as a group and (c) 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 materially alter the allocation of the benefits as between the groups specified in subparagraph (b) (3) of this item, the nature of such amendments should be specified.

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 amount of securities called for or to be called for by warrants received or to be received by the following persons, naming each such person: (1) each person named in item 7 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.

11. Authorization or issuance of securities.

(a) 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.

(b) If the shares of 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, pre-emptive and conversion rights, redemption and sinking fund provisions, interest rate and date of maturity.

(c) If the shares of 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.

12. Mergers, consolidations, acquisitions and similar matters. (a) If action is to be taken with respect to a merger, consolidation, acquisition or similar matter, furnish in brief outline the following information: (1) 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; (2) the material features of the plan or agreement; (3) the business

done by the company to be acquired or whose assets are being acquired; (4) if available, the high and low sales prices for each quarterly period within two years; (5) the percentage of outstanding shares which must approve the transaction before it is consummated.

(b) For each company involved in a merger, consolidation or acquisition, the following financial statements should be furnished: (1) A comparative balance sheet as of the close of the last two fiscal years; (2) 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; (3) 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.

13. Restatement of accounts. If action is to be taken with respect to the restatement of any asset, capital or surplus 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.

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.

15. Amendment of charter, bylaws or other documents. If action is to be taken with respect to any amendment of the insurer's charter, bylaws 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.

(Effective September 25, 1992)

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

1. Insurer. State the name and address of the insurer.

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.

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 latest 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 loss 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.

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.

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)

EXHIBIT 1

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

SCHEDULE SIS

STOCKHOLDER INFORMATION SUPPLEMENT

REQUIRED BY QUESTION 10 GENERAL INTERROGATORIES (FIRE AND CASUALTY BLANK),
QUESTION 4A (LIFE AND ACCIDENT AND HEALTH BLANK), AND
QUESTION 16 (TITLE INSURANCE BLANK)

TO ANNUAL STATEMENT OF THE

COMPANY

To The Insurance Department

OF THE STATE OF

CONNECTICUT

FOR THE YEAR ENDED

DECEMBER 31, 19 __

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High Deductible Health Plans for Health Care Centers

Sec. 38a-192-1. Definitions

As used in Sections 38a-192-1 to 38a-192-3 inclusive:

- (1) “Annual” means any 12 month period as determined by the contract;
- (2) “Commissioner” means the Insurance Commissioner;
- (3) “Copay” means a flat fee that an enrollee or member is required to pay each time a specified service is rendered;
- (4) “Deductible” means the amount of covered expenses which must be accumulated annually before benefits become payable as additional covered expenses incurred;
- (5) “Enrollee” means “enrollee” as defined in section 38a-175(14) of the Connecticut General Statutes;
- (6) “Health Care Center” means “health care center” as defined in section 38a-175(9) of the Connecticut General Statutes;
- (7) “High Deductible Plan” means a contract for health care services that has an annual deductible for individuals of not less than \$1,500 for in-network services and an annual deductible for families of not less than \$3,000;
- (8) “Member” means “member” as defined in section 38a-175(14) of the Connecticut General Statutes; and
- (9) “Provider” means “provider” as defined in section 38a-175(19) of the Connecticut General Statutes.

(Adopted effective September 3, 2008)

Sec. 38a-192-2. Method of providing access to health care

(a) In addition to the methods set forth in section 38a-177 of the Connecticut General Statutes and subject to section 38a-183 of the Connecticut General Statutes, a health care center may provide access to health care through the use of a high deductible plan.

(b) Only expenses for health care services that are generally covered by the non-deductible portion of the contract may be applied against the deductible. This restriction includes limitations on particular providers, including in-network and out-of-network providers, if any, as set forth in the contract.

(c) Deductibles shall not be limited to single benefit services only.

(d) The expense for health care services applied against the deductible shall be the actual amount paid to the provider by the member, enrollee or their designee on behalf of the member or enrollee, excluding any amounts in excess of the negotiated allowable expense and any copay amounts paid by the member, enrollee or their designee on behalf of the member or enrollee.

(e) If a high deductible health plan is intended to be federally tax qualified, there shall be disclosure on the face page of the policy in quarter inch type or contrasting color that states: “This policy is intended to be federally tax qualified. Approval by the Insurance Department does not guarantee tax qualification and members and enrollees are encouraged to seek the counsel of a tax advisor”.

(Adopted effective September 3, 2008)

Sec. 38a-192-3. Reporting of high deductible plans

Each health care center shall report all high deductible plan business pursuant to the financial reporting requirements established by the National Association of Insurance Commissioners and the Insurance Department.

(Adopted effective September 3, 2008)

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Risk-Based Capital Requirements For Health Care Centers

Sec. 38a-193-1. Definitions

As used in sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies:

(1) “Adjusted RBC report” means an RBC report which has been adjusted by the commissioner in accordance with section 38a-193-2(c) of the Regulations of Connecticut State Agencies;

(2) “Commissioner” means the Insurance Commissioner of the State of Connecticut;

(3) “Corrective order” means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required;

(4) “Health care center” means a “health care center” as defined in section 38a-175 of the Connecticut General Statutes. This definition does not include an organization that is licensed as an insurance company under section 38a-41 of the Connecticut General Statutes and that is otherwise subject to the financial requirements of section 38a-72 of the Connecticut General Statutes;

(5) “NAIC” means the National Association of Insurance Commissioners;

(6) “RBC” means risk-based capital;

(7) “RBC instructions” means the RBC report including risk-based capital instructions adopted by the NAIC, as these RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC;

(8) “RBC level” means a health care center’s Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC where:

(A) “Company Action Level RBC” means, with respect to any health care center, the product of 2.0 and its Authorized Control Level RBC;

(B) “Regulatory Action Level RBC” means the product of 1.5 and its Authorized Control Level RBC;

(C) “Authorized Control Level RBC” means the number determined under the risk-based capital formula in accordance with the RBC Instructions; and

(D) “Mandatory Control Level RBC” means the product of .70 and the Authorized Control Level RBC;

(9) “RBC plan” means a comprehensive financial plan containing the elements specified in section 38a-193-3(b) of the Regulations of Connecticut State Agencies. If the commissioner rejects the RBC plan, and it is revised by the health care center, with or without the commissioner’s recommendation, the plan shall be called the “revised RBC plan;”

(10) “RBC report” means the report required in section 38a-193-2 of the Regulations of Connecticut State Agencies; and

(11) “Total adjusted capital” means the sum of: a health care center’s statutory capital and surplus and such other items, if any, as the RBC instructions may provide.

(Adopted effective January 31, 2000; amended August 30, 2004)

Sec. 38a-193-2. RBC reports

(a) Every health care center shall, on or prior to each March 1 (the “filing date”), prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, a health care center shall file its RBC report with the NAIC in accordance with the RBC instructions.

(b) A health care center's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula may be adjusted for the covariance between the risks set forth in subdivisions (1) to (4), inclusive, of this subsection. The formula shall take the following into account, determined in each case by applying the factors in the manner set forth in the RBC instructions.

- (1) Asset risk;
- (2) credit risk;
- (3) underwriting risk; and
- (4) all other business risks and such other relevant risks as are set forth in the RBC instructions.

(c) If a health care center files a RBC report that in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the health care center of the adjustment. The notice shall contain a statement of the reason for the adjustment. A RBC report as so adjusted is referred to as an "adjusted RBC report."

(Adopted effective January 31, 2000; amended August 30, 2004)

Sec. 38a-193-3. Company action level event

(a) As used in sections 38a-193-1 to 38a-198-13, inclusive, of the Regulations of Connecticut State Agencies, "Company Action Level Event" means any of the following events:

(1) The filing of an RBC report by a health care center that indicates that the health care center's total adjusted capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC;

(2) If a health care center has total adjusted capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the Health RBC instructions;

(3) notification by the commissioner to the health care center of an adjusted RBC report that indicates an event in subdivision (1) of this subsection, provided the health care center does not challenge the adjusted RBC report under section 38a-193-7 of the Regulations of Connecticut State Agencies; or

(4) if, pursuant to section 38a-193-7 of the Regulations of Connecticut State Agencies, a health care center challenges an adjusted RBC report that indicates the event in subdivision (1) of this subsection, the notification by the commissioner to the health care center that the commissioner has, after a hearing, rejected the health care center's challenge.

(b) In the event of a Company Action Level Event, the health care center shall prepare and submit to the commissioner a RBC plan that shall:

(1) Identify the conditions that contribute to the Company Action Level Event;

(2) contain proposals of corrective actions that the health care center intends to take and that would be expected to result in the elimination of the Company Action Level Event;

(3) provide projections of the health care center's financial results in the current year and at least the two (2) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(4) identify the key assumptions impacting the health care center's projections and the sensitivity of the projections to the assumptions; and

(5) identify the quality of, and problems associated with, the health care center's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(c) The RBC plan shall be submitted not later than forty-five (45) days after the Company Action Level Event; or if the health care center challenges an adjusted RBC report pursuant to section 38a-193-7 of the Regulations of Connecticut State Agencies, not later than forty-five (45) days after notification to the health care center that the commissioner has, after a hearing, rejected the health care center's challenge.

(d) Not later than sixty (60) days after the submission by a health care center of an RBC plan to the commissioner, the commissioner shall notify the health care center whether the RBC plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, the notification to the health care center shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the health care center shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner not later than forty-five (45) days after the notification from the commissioner; or if the health care center challenges the notification from the commissioner under section 38a-193-7 of the Regulations of Connecticut State Agencies, not later than forty-five (45) days after a notification to the health care center that the commissioner has, after a hearing, rejected the health care center's challenge.

(e) In the event of a notification by the commissioner to a health care center that the health care center's RBC plan or revised RBC plan is unsatisfactory, the commissioner may, subject to the health care center's right to a hearing under section 38a-193-7 of the Regulations of Connecticut State Agencies, specify in the notification that the notification constitutes a Regulatory Action Level Event.

(Adopted effective January 31, 2000; amended August 30, 2004, November 1, 2010)

Sec. 38a-193-4. Regulatory action level event

(a) As used in Sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies, "Regulatory Action Level Event" means, with respect to a health care center, any of the following events:

(1) The filing of a RBC report by the health care center that indicates that the health care center's total adjusted capital is greater than or equal to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;

(2) notification by the commissioner to a health care center of an adjusted RBC report that indicates the event in subdivision (1) of this subsection, provided the health care center does not challenge the adjusted RBC report under section 38a-193-7 of the Regulations of Connecticut State Agencies;

(3) if, pursuant to section 38a-193-7 of the Regulations of Connecticut State Agencies, the health care center challenges an adjusted RBC report that indicates the event in subdivision (1) of this subsection, the notification by the commissioner to the health care center that the commissioner has, after a hearing, rejected the health care center's challenge;

(4) the failure of the health care center to file a RBC report by the filing date, unless the health care center has provided an explanation for the failure that is

satisfactory to the commissioner and has cured the failure not later than ten (10) days after the filing date;

(5) the failure of the health care center to submit a RBC plan to the commissioner within the time period set forth in section 38a-193-3(c) of the Regulations of Connecticut State Agencies;

(6) notification by the commissioner to the health care center that the RBC plan or revised RBC plan submitted by the health care center is, in the judgment of the commissioner, unsatisfactory; Notification constitutes a Regulatory Action Level Event with respect to the health care center, provided the health care center has not challenged the determination under section 38a-193-7 of the Regulations of Connecticut State Agencies;

(7) if, pursuant to section 38a-193-7 of the Regulations of Connecticut State Agencies, the health care center challenges a determination by the commissioner under subdivision (6) of this subsection, the notification by the commissioner to the health care center that the commissioner has, after a hearing, rejected the challenge;

(8) notification by the commissioner to the health care center that the health care center has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the health care center to eliminate the Company Action Level Event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification, provided the health care center has not challenged the determination under section 38a-193-7 of the Regulations of Connecticut State Agencies; or

(9) if, pursuant to section 38a-193-7 of the Regulations of Connecticut State Agencies, the health care center challenges a determination by the commissioner under subdivision (8) of this subsection, the notification by the commissioner to the health care center that the commissioner has, after a hearing, rejected the challenge.

(b) In the event of a Regulatory Action Level Event the commissioner shall:

(1) Require the health care center to prepare and submit a RBC plan or, if applicable, a revised RBC plan;

(2) perform such examination or analysis as the commissioner deems necessary of the assets, liabilities and operations of the health care center including a review of its RBC plan or revised RBC plan; and

(3) subsequent to the examination or analysis, issue an order specifying such corrective actions as the commissioner shall determine are required (a "corrective order").

(c) In determining corrective actions, the commissioner may take into account factors the commissioner deems relevant with respect to the health care center based upon the commissioner's examination or analysis of the assets, liabilities and operations of the health care center, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(1) Not later than forty-five (45) days after the occurrence of the Regulatory Action Level Event;

(2) if the health care center challenges an adjusted RBC report pursuant to section 38a-193-7 of the Regulations of Connecticut State Agencies and the challenge is not frivolous in the judgment of the commissioner, not later than forty-five (45) days after the notification to the health care center that the commissioner has, after a hearing, rejected the health care center's challenge; or

(3) if the health care center challenges a revised RBC plan pursuant to section 38a-193-7 of the Regulations of Connecticut State Agencies and the challenge is not frivolous in the judgment of the commissioner, not later than forty-five (45)

days after the notification to the health care center that the commissioner has, after a hearing, rejected the health care center's challenge.

(d) The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the health care center's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations (including contractual relationships) of the health care center and formulate the corrective order with respect to the health care center. The fees, costs and expenses relating to consultants shall be borne by the affected health care center or such other party as directed by the commissioner.

(Adopted effective January 31, 2000)

Sec. 38a-193-5. Authorized control level event

(a) As used in Sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies, "Authorized Control Level Event" means any of the following events:

(1) The filing of a RBC report by the health care center that indicates that the health care center's total adjusted capital is greater than or equal to its Mandatory Control Level RBC but less than its Authorized Control Level RBC;

(2) the notification by the commissioner to the health care center of an adjusted RBC report that indicates the event in subdivision (1) of this subsection, provided the health care center does not challenge the adjusted RBC report under section 38a-193-7 of the Regulations of Connecticut State Agencies;

(3) if, pursuant to section 38a-193-7 of the Regulations of Connecticut State Agencies, the health care center challenges an adjusted RBC report that indicates the event in subdivision (1) of this subsection, notification by the commissioner to the health care center that the commissioner has, after a hearing, rejected the health care center's challenge;

(4) the failure of the health care center to respond, in a manner satisfactory to the commissioner, to a corrective order (provided the health care center has not challenged the corrective order under section 38a-193-7 of the Regulations of Connecticut State Agencies); or

(5) if the health care center has challenged a corrective order under section 38a-193-7 of the Regulations of Connecticut State Agencies and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health care center to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(b) In the event of an Authorized Control Level Event with respect to a health care center, the commissioner shall:

(1) Take such actions as are required under section 38a-193-4 of the Regulations of Connecticut State Agencies regarding a health care center with respect to which a Regulatory Action Level Event has occurred; or

(2) if the commissioner deems it to be in the best interests of the policyholders and creditors of the health care center and of the public, take such actions as are necessary to cause the health care center to be placed under regulatory control under Chapter 704c of the Connecticut General Statutes. In the event the commissioner takes such actions, the Authorized Control Level Event shall be deemed sufficient grounds for the commissioner to take action under Chapter 704c of the Connecticut General Statutes, and the commissioner shall have the rights, powers and duties with respect to the health care center as are set forth in Chapter 704c of the Connecticut General Statutes. In the event the commissioner takes action under this paragraph pursuant to an adjusted RBC report, the health care center shall be

entitled to such protections as are afforded to health care centers under the provisions Chapter 704c of the Connecticut General Statutes pertaining to summary proceedings.

(Adopted effective January 31, 2000)

Sec. 38b-193-6. Mandatory control level event

(a) As used in Sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies, “Mandatory Control Level Event” means any of the following events:

(1) The filing of a RBC report which indicates that the health care center’s total adjusted capital is less than its Mandatory Control Level RBC;

(2) notification by the commissioner to the health care center of an adjusted RBC report that indicates the event in subdivision (1) of this subsection, provided the health care center does not challenge the adjusted RBC report under section 38a-193-7 of the Regulations of Connecticut State Agencies; or

(3) if, pursuant to section 38a-193-7 of the Regulations of Connecticut State Agencies, the health care center challenges an adjusted RBC report that indicates the event in subdivision (1) of this subsection, notification by the commissioner to the health care center that the commissioner has, after a hearing, rejected the health care center’s challenge.

(b) In the event of a Mandatory Control Level Event, the commissioner shall take such actions as are necessary to place the health care center under regulatory control under Chapter 704c of the Connecticut General Statutes. In that event, the Mandatory Control Level Event shall be deemed sufficient grounds for the commissioner to take action under Chapter 704c of the Connecticut General Statutes, and the commissioner shall have the rights, powers and duties with respect to the health care center as are set forth in Chapter 704c of the Connecticut General Statutes. In the event the commissioner takes actions pursuant to an adjusted RBC report, the health care center shall be entitled to the protections of Chapter 704c of the Connecticut General Statutes pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety (90) days after the Mandatory Control Level Event if the commissioner finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety-day period.

(Adopted effective January 31, 2000)

Sec. 38a-193-7. Hearings

The health care center shall have the right to a departmental hearing, on a record, at which the health care center may challenge any determination or action by the commissioner upon:

(1) Notification to a health care center by the commissioner of an adjusted RBC report;

(2) notification to a health care center by the commissioner that the health care center’s RBC plan or revised RBC plan is unsatisfactory; and Notification constitutes a Regulatory Action Level Event with respect to the health care center;

(3) notification to a health care center by the commissioner that the health care center has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the health care center to eliminate the Company Action Level Event with respect to the health care center in accordance with its RBC plan or revised RBC plan; or

(4) notification to a health care center by the commissioner of a corrective order with respect to the health care center.

(Adopted effective January 31, 2000)

Sec. 38a-193-8. Confidentiality and prohibition on announcements

(a) All RBC reports (to the extent the information is not required to be set forth in a publicly available annual statement schedule) and RBC plans (including the results or report of any examination or analysis of a health care center performed pursuant to sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies and any corrective order issued by the commissioner pursuant to examination or analysis) with respect to a health care center that are filed with the commissioner constitute information that might be damaging to the health care center if made available to its competitors, and therefore shall be kept confidential by the commissioner pursuant to the authority of sections 38a-14, 38a-69a, 38a-913 and 38a-962c of the Connecticut General Statutes. All RBC reports and RBC plans shall be construed as “commercial or financial information given in confidence” as provided under section 1-210(b)(5) of the Connecticut General Statutes. This information shall not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies or any other provision of the insurance laws or regulations of this state or as provided by law.

(b) The comparison of a health care center’s total adjusted capital to any of its RBC levels is a regulatory tool which may indicate the need for corrective action with respect to the health care center, and is not intended as a means to rank health care centers generally. Therefore, except as otherwise required under the provisions of sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies the making, publishing, disseminating, circulating or placing before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over a radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any health care center, or of any component derived in the calculation, by any health care center, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the comparison regarding a health care center’s total adjusted capital to its RBC levels (or any of them) or an inappropriate comparison of any other amount to the health care centers’ RBC levels is published in any written publication and the health care center is able to demonstrate to the commissioner with substantial proof the falsity of the statement, or the inappropriateness, as the case may be, then the health care center may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(c) The RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of health care centers and the need for possible corrective action with respect to health care centers and shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium

level or rate of return for any line of insurance that a health care center or any affiliate is authorized to write.

(Adopted effective January 31, 2000; amended August 30, 2004)

Sec. 38a-193-9. Supplemental provisions; exemption

(a) The provisions of sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies are supplemental to any other provisions of the laws and regulations of this state, and shall not preclude or limit any other powers or duties of the commissioner under such laws, including, but not limited to, Chapter 704c of the Connecticut General Statutes and sections 38a-8-101 to 38a-8-104, inclusive, of the Regulations of Connecticut State Agencies.

(b) The commissioner may exempt from the application of sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies a health care center that: (1) assumes no reinsurance in excess of five percent (5%) of direct premium written; and (2) writes direct annual premiums for comprehensive medical business of \$2,000,000 or less.

(Adopted effective January 31, 2000; amended August 30, 2004)

Sec. 38a-193-10.

Repealed, August 30, 2004.

Sec. 38a-193-11. Notices

All notices by the commissioner to a health care center that may result in regulatory action under sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the health care center's receipt of notice.

(Adopted effective January 31, 2000)

Sec. 38a-193-12.

Repealed, August 30, 2004.

Sec. 38a-193-13. Severability

If any provision of sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies or its application to any person or circumstance, is held invalid by a court of competent jurisdiction, that determination shall not affect the provisions or applications of sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies that can be given effect without the invalid provision or application, and to that end the provisions of sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies are severable.

(Adopted effective January 31, 2000)

193-13, inclusive, of the Regulations of Connecticut State Agencies), if the insurance commissioner of the state of domicile of the foreign health care center fails to require the foreign health care center to file a RBC plan in the manner specified under that state's RBC statute (or, if no RBC statute is in force in that state, under section 38a-193-3 of the Regulations of Connecticut State Agencies), the commissioner may require the foreign health care center to file a RBC plan with the commissioner. In such event, the failure of the foreign health care center to file a RBC plan with the commissioner shall be grounds to order the health care center to cease and desist from writing new insurance business in this state.

(c) In the event of a Mandatory Control Level Event with respect to a foreign health care center, if no domiciliary receiver has been appointed with respect to the foreign health care center under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign health care center, the commissioner may make application to the Superior Court permitted under the Chapter 704c of the Connecticut General Statutes with respect to the liquidation of property of foreign health care centers found in this state, and the occurrence of the Mandatory Control Level Event shall be considered adequate grounds for the application.

(Adopted effective January 31, 2000)

Sec. 38a-193-11. Notices

All notices by the commissioner to a health care center that may result in regulatory action under sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the health care center's receipt of notice.

(Adopted effective January 31, 2000)

Sec. 38a-193-12. Phase-in provision

For RBC reports required to be filed by health care centers with respect to 1999 and 2000, the following requirements shall apply in lieu of the provisions of sections 38a-193-3, 38a-193-4, 38a-193-5 and 38a-193-6 of the Regulations of Connecticut State Agencies:

(1) In the event of a Company Action Level Event with respect to a domestic health care center, the commissioner shall take no regulatory action under sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies;

(2) in the event of a Regulatory Action Level Event under sections 38a-193-4(a)(1), 38a-193-4(a)(2) or 38a-193-4(a)(3) of the Regulations of Connecticut State Agencies the commissioner shall take the actions required under section 38a-193-3 of the Regulations of Connecticut State Agencies;

(3) in the event of a Regulatory Action Level Event under sections 38a-193-4(a)(4), 38a-193-4(a)(5), 38a-193-4(a)(6), 38a-193-4(a)(7), 38a-193-4(a)(8) or 38a-193-4(a)(9) of the Regulations of Connecticut State Agencies or an Authorized Control Level Event, the commissioner shall take the actions required under section 38a-193-4 of the Regulations of Connecticut State Agencies with respect to the health care center; and

(4) in the event of a Mandatory Control Level Event with respect to a health care center, the commissioner shall take the actions required under section 38a-193-5 of the Regulations of Connecticut State Agencies with respect to the health care center.

(Adopted effective January 31, 2000)

Sec. 38a-193-13. Severability

If any provision of sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies or its application to any person or circumstance, is held invalid by a court of competent jurisdiction, that determination shall not affect the provisions or applications of sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies that can be given effect without the invalid provision or application, and to that end the provisions of sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies are severable.

(Adopted effective January 31, 2000)

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Standards for Approval of Clinics

Sec. 38a-199-1. Clinic defined

For the purposes of sections 38a-199-2 to 38a-199-6, inclusive, of these regulations a clinic is an organization which provides out-patient medical or dental care for diagnosis, treatment and care of persons with chronic or acute conditions.

(Effective September 25, 1992)

Sec. 38a-199-2. Building and equipment requirements

(a) A clinic building shall be of sound construction and shall provide adequate space and equipment for patient interviews, physical examinations and treatment of patients and for service and other areas in accordance with the requirements of the state department of health.

(b) Clinic buildings and equipment shall meet the requirements of the state fire safety code. Annual application for approval shall be accompanied by a certificate of inspection by the local fire marshal.

(c) Areas in which explosive gases or radioactive materials are used shall provide for adequate protection of patients and personnel.

(d) The clinic buildings and equipment shall be maintained in a good state of repair and shall be kept clean at all times.

(Effective September 25, 1992)

Sec. 38a-199-3. Governing board. Administrator. Personnel

(a) A clinic shall be managed by a governing board whose duties shall include, as a minimum: (1) Adoption of bylaws, rules and regulations, including medical or dental staff bylaws or both; (2) annual appointment of the medical or dental staff with annual designation of a medical or dental director; (3) appointment of a clinic administrator qualified on the basis of training and experience approved by the commissioner of health.

(b) The administrator shall be responsible to the governing board for the management and operation of the clinic and for the employment of personnel. He shall attend meetings of the governing board and meetings of the professional staff.

(c) Personnel shall be employed in sufficient numbers and of adequate qualifications so that the functions of the clinic may be performed efficiently.

(Effective September 25, 1992)

Sec. 38a-199-4. Professional staff

(a) There shall be an organized professional staff of not fewer than three members of the major profession or professions providing care in the clinic and, in a rehabilitation clinic, a staff including a medical director and physical therapist and one other major profession providing care in the clinic.

(b) The professional staff shall adopt written rules or regulations governing its own activities, subject to approval of the governing board of the clinic. As a minimum these shall include: (1) Methods of control of privileges granted to members of the medical or dental staff and the responsibilities of the medical or dental director; (2) method of professional supervision of clinical work; (3) provision for regular staff meetings; (4) preparation of adequate case records; (5) procedure for recommending appointments to the staff and for hearing complaints regarding the conduct of members, referring the same, with recommendations, to the governing board.

(Effective September 25, 1992)

Sec. 38a-199-5. Records

(a) There shall be a medical or dental records department with adequate space and equipment and qualified personnel.

(b) A medical or dental record shall be started for each patient at the time of admission, including proper identifying data. Medical and dental records shall include sufficient information to justify the diagnosis and warrant the treatment given. Each entry shall be signed by the person responsible for it.

(c) Medical and dental records shall be filed in an accessible manner in the clinic, with proper provision for their confidentiality, and shall be kept for a minimum of five years after discharge of the patient.

(Effective September 25, 1992)

Sec. 38a-199-6. General requirement for health, comfort and safety

The management, personnel, equipment, facilities, sanitation and maintenance of the clinic shall be such as reasonably to assure the health, comfort and safety of patients at all times.

(Effective September 25, 1992)

Reserve Requirements for Hospital Service Corporation

Sec. 38a-199-7. Authority

The following regulations are adopted pursuant to Section 38a-199 of the General Statutes of Connecticut as amended by Section 1 of Public Act 74-5 and, as applicable, Public Act 74-7.

(Effective September 25, 1992)

Sec. 38a-199-8. Definitions

As used in Reg. Sec. 38a-199-7 to Reg. Sec. 38a-199-13: “Ascertained Experience” means the loss and expense ratio for the most recent twelve-month period of operation, or such other period as the commissioner may deem appropriate.

“Commissioner” means the insurance commissioner.

“Contingency Reserves” and “Reserve for Contingencies” means the unassigned funds held over and above the Policy Contract Liability Reserves as defined in these regulations and all other liabilities.

“Policy Contract Liability Reserves” means the reserves held for present claims or claims in process plus the reserves held for future or deferred benefits and for unearned premiums.

All technical words and phrases and such as have acquired a peculiar and appropriate meaning in the law and in the field of insurance shall be construed and understood accordingly.

(Effective September 25, 1992)

Sec. 38a-199-9. Policy contract liability reserves

Each hospital service corporation shall maintain Policy Contract Liability Reserves at a level consistent with the following requirements:

Minimum. An amount sufficient to pay and adjust all present claims and claims in process when and as such claims become due, plus an amount sufficient to pay and adjust all future claims or deferred benefits as and when such benefits become due and to cover unearned premiums. The standards of payment and adjustment of claims when and as such become due shall be in accordance with the standards

required of insurance companies under the provisions of Section 38a-17 of the General Statutes of Connecticut, as it may from time to time be amended.

Maximum. An amount not to exceed the minimum as hereinbefore defined plus amounts computed and as approved by the commissioner to compensate for inflationary trends, projected increased costs for the future or deferred benefits, interest charges which may become due on settlement of disputed claims, and changing claim frequency in respect to future or deferred benefits.

(Effective September 25, 1992)

Sec. 38a-199-10. Contingency reserves

Each hospital service corporation shall maintain Contingency Reserves at a minimum level computed on the following basis:

The amount required by insurance companies licensed to transact accident and health insurance, under Section 38a-72 of the General Statutes as it may from time to time be amended, plus the greater of (1) an amount equal to the average monthly cost of claims and expense for the preceding twelve months or (2) an amount which bears a reasonable relation to the liabilities of such corporation.

If a corporation's reserve falls below an amount equal to Section 38a-72 plus the net loss in the previous two years, the corporation shall act to restore the reserve to at least that amount.

Permissible additions to minimum. Subject to the approval of the commissioner, in addition to such minimum Contingency Reserves, further Contingency Reserves may be accumulated by the subject corporation based upon the following factors:

(1) Stability, solvency, and interest of the corporation and the interests of the policyholders and other affected persons, including such specific objectives as rate stability, inflationary trends, deviations from the forecast of changing claim frequency, market fluctuations, and the possibility of epidemics and catastrophes;

(2) Present or projected public service pilot projects which are undertaken for the purpose of providing more and better care in the manner most economical to the subscribers;

(3) Costs of consolidations, acquisitions, or mergers as provided by law;

(4) Capital expenditures reasonably related to the general purposes of the corporation;

(5) Proposed increases in benefits without fully compensating rate increases;

(6) Projected profit or loss forecasts together with any other factors reasonably tending to justify the maintenance, increase, or decrease of any such Contingency Reserve.

Maximum. No hospital service corporation subject to these regulations shall maintain Contingency Reserves in amounts greater than the minimum as hereinabove defined, plus the permissible additions to the minimum prescribed above and provided the approval of the commissioner has been obtained prior to the reserving of the permissible additions.

Maximum limit. The maximum Contingency Reserves which may be maintained by any hospital service corporation subject to these regulations shall in no event be greater than an amount equal to 50 percent of the preceding twelve months cost of claims and expense of such corporation.

(Effective September 25, 1992)

Sec. 38a-199-11. Changes in contingency reserve levels

The commissioner may, after a hearing called at the request of any interested person admitted as a party for the purpose of any such hearing or on his own motion,

order the maintenance, increase, or decrease of any such Contingency Reserve, whether in connection with a rate change or otherwise, consistent with these regulations and other requirements, and may require such hospital service corporation to adjust its rates or benefits or both to accomplish any adjustment in such reserve.

(Effective September 25, 1992)

Sec. 38a-199-12. Standards

In permitting and approving adjustments in accordance with these regulations, the commissioner may consider the Ascertained Experience of the hospital service corporation and may use as a basis such reasonable periods of time as he may deem appropriate. The commissioner in determining the computations shall consider the interest of the subscribers and the solvency of the hospital service corporation.

(Effective September 25, 1992)

Sec. 38a-199-13. Effective date

These regulations shall take effect on filing with the secretary of the state as provided in Section 4-172 of the General Statutes.

(Effective September 25, 1992)

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Reserve Requirements for Medical Service Corporations

Sec. 38a-214-1. Authority

The following regulations are adopted pursuant to Section 38a-214 of the General Statutes of Connecticut as amended by Section 2 of Public Act 74-5 and, as applicable, Public Act 74-7.

(Effective September 25, 1992)

Sec. 38a-214-2. Definitions

As used in Reg. Sec. 38a-214-1 to Reg. Sec. 38a-214-7:

“Ascertained Experienced” means the loss and expense ratio for the most recent twelve-month period of operation, or such other period as the commissioner may deem appropriate.

“Commissioner” means the insurance commissioner.

“Contingency Reserves” and “Reserve for Contingencies” means the unassigned funds held over and above the Policy Contract Liability Reserves as defined in these regulations and all other liabilities.

“Policy Contract Liability Reserves” means the reserves held for present claims or claims in process plus the reserves held for future or deferred benefits and for unearned premiums.

All technical words and phrases and such as have acquired a peculiar and appropriate meaning in the law and in the field of insurance shall be construed and understood accordingly.

(Effective September 25, 1992)

Sec. 38a-214-3. Policy contract liability reserves

Each medical service corporation shall maintain Policy Contract Liability Reserves at a level consistent with the following requirements:

Minimum. An amount sufficient to pay and adjust all present claims and claims in process when and as such claims become due, plus an amount sufficient to pay and adjust all future claims or deferred benefits as and when such benefits become due and to cover unearned premiums. The standards of payment and adjustment of claims when and as such become due shall be in accordance with the standards required of insurance companies under the provisions of Section 38a-17 of the General Statutes of Connecticut, as it may from time to time be amended.

Maximum. An amount not to exceed the minimum as hereinbefore defined plus amounts computed and as approved by the commissioner to compensate for inflationary trends, projected increased costs for the future or deferred benefits, interest charges which may become due on settlement of disputed claims, and changing claim frequency in respect to future or deferred benefits.

(Effective September 25, 1992)

Sec. 38a-214-4. Contingency reserves

Each medical service corporation shall maintain Contingency Reserves at a minimum level computed on the following basis:

The amount required by insurance companies licensed to transact accident and health insurance, under Section 38-93 of the General Statutes as it may from time to time be amended, plus the greater of (1) an amount equal to the average monthly cost of claims and expense for the preceding twelve months or (2) an amount which bears a reasonable relation to the liabilities of such corporation.

If a corporation's reserve falls below an amount equal to Section 38a-72 plus the net loss in the previous two years, the corporation shall act to restore the reserve to at least that amount.

Permissible additions to minimum. Subject to the approval of the commissioner, in addition to such minimum Contingency Reserves, further Contingency Reserves may be accumulated by the subject corporation based upon the following factors:

(1) Stability, solvency, and interest of the corporation and the interests of the policyholders and other affected persons, including such specific objectives as rate stability, inflationary trends, deviations from the forecast of changing claim frequency, market fluctuations, and the possibility of epidemics and catastrophes;

(2) Present or projected public service pilot projects which are undertaken for the purpose of providing more and better care in the manner most economical to the subscribers;

(3) Costs of consolidations, acquisitions, or mergers as provided by law;

(4) Capital expenditures reasonably related to the general purposes of the corporation;

(5) Proposed increases in benefits without fully compensating rate increases;

(6) Projected profit or loss forecasts together with any other factors reasonably tending to justify the maintenance, increase, or decrease of any such Contingency Reserve.

Maximum. No medical service corporation nor any merged corporation subject to these regulations shall maintain Contingency Reserves in amounts greater than the minimum as hereinabove defined, plus the permissible additions to the minimum prescribed above and provided the approval of the commissioner had been obtained prior to the reserving of the permissible additions.

Maximum limit. The maximum Contingency Reserves which may be maintained by any medical service corporation subject to these regulations shall in no event be greater than an amount equal to 50 percent of the preceding twelve months cost of claims and expense of such corporation.

(Effective September 25, 1992)

Sec. 38a-214-5. Changes in contingency reserve levels

The commissioner may, after a hearing called at the request of any interested person admitted as a party for the purpose of any such hearing or on his own motion, order the maintenance, increase, or decrease of any such Contingency Reserve, whether in connection with a rate change or otherwise, consistent with these regulations and other requirements, and may require such medical service or merged corporation to adjust its rates or benefits or both to accomplish any adjustment in such reserve.

(Effective September 25, 1992)

Sec. 38a-214-6. Standards

In permitting and approving adjustments in accordance with these regulations, the commissioner may consider the Ascertained Experience of the medical service corporation and may use as a basis such reasonable periods of time as he may deem appropriate. The commissioner in determining the computations shall consider the interest of the subscribers and the solvency of the medical service corporation.

(Effective September 25, 1992)

Sec. 38a-214-7. Effective date

These regulations shall take effect on filing with the secretary of the state as provided in Section 4-172 of the General Statutes.

(Effective September 25, 1992)

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Repealed 38a-226c-1—38a-226c-10

Utilization Review

Secs. 38a-226c-1—38a-226c-10.

Repealed, September 4, 2012.

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Reporting Requirements for Licensees Seeking to do Business With Certain Unauthorized Multiple Employer Welfare Arrangements

Sec. 38a-272-1. Authority

Sections 38a-272-1 to 38a-272-10, inclusive, are adopted pursuant to the authority of Section 38a-8 of the General Statutes as necessary to implement Sections 38a-271 to 38a-278, inclusive, 38a-703, and 38a-815 of the General Statutes.

(Effective September 25, 1992)

Sec. 38a-272-2. Purpose

The Insurance Department has become aware that certain health benefit arrangements have been transacting unauthorized insurance in this state with the assistance and through the professional services of persons licensed by the Department. In many cases these arrangements claim that state insurance laws and regulations applicable to the entity are preempted by the federal Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.* Licensees apparently have believed that they can provide professional services to such arrangements under a claimed ERISA preemption. Often, such arrangements are singularly referred to as a multiple employer welfare arrangement ("MEWA").

However, recent advisory opinions from the U.S. Department of Labor have made it clear that the ERISA preemption claims of many of these arrangements are false and that state insurance laws and regulations, including state laws related to the transaction of unauthorized insurance, are fully applicable to many arrangements that have claimed ERISA preemption.

The purpose of this regulation is to require licensed agents, brokers, and insurers to submit information to the Insurance Department prior to assisting in any way the transaction of insurance by certain types of multiple employer arrangements identified in this regulation. These reports will help the Department identify unauthorized insurance arrangements so that they can protect themselves from potential liability for assisting in the transaction of unauthorized insurance.

(Effective September 25, 1992)

Sec. 38a-272-3. Definitions

As used in Sections 38a-272-3 to 38a-272-10 inclusive:

(a) "Arrangement" means a fund, trust, plan, program or other mechanism by which a person provides, or attempts to provide, health care benefits to individuals.

(b) "Collectively bargained arrangement" means an arrangement which provides or represents that it is providing health care benefits or coverage under or pursuant to one or more collective bargaining agreements. "Collectively bargained arrangement" does not include an arrangement that is fully insured by a licensed insurer.

(c) "Commissioner" means the insurance commissioner of this state.

(d) "Employee leasing arrangement" means labor leasing, staff leasing, employee leasing, contract labor, extended employee staffing or supply, or other arrangements, under contract or otherwise, whereby one business or entity leases or obtains all or a significant number of its workers from another business or entity.

(e) "Employee welfare benefit plan" means any plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical

or hospital care benefits, or benefits in the event of sickness, accident disability, death or unemployment.

(f) “Fully insured by a licensed insurer” means that, for all of the health care benefits or coverage provided or offered by or through an arrangement:

(1) A licensed insurer is directly obligated by contract to provide all of the coverage to or under the arrangement;

(2) The licensed insurer assumes all of the risk for payment of all covered services or benefits; and

(3) The liability of the licensed insurer for payment of the covered services or benefits runs directly to the individual employee, member or dependent receiving the health care services.

(g) “Licensed insurer” means an insurer, as defined in Section 38a-271 of the General Statutes, having a certificate of authority from the Commissioner to transact insurance in this state.

(h) “Producer” means insurance producer as defined in subdivision (1) of Section 38a-702 of the Connecticut General Statutes.

(i) “Reportable MEWA” means a person that provides health care benefits or coverage to the employees of two or more employers. “Reportable MEWA” does not include:

(1) A licensed insurer;

(2) An arrangement which is fully insured by a licensed insurer;

(3) A collectively bargained arrangement;

(4) An employee welfare benefit plan established or maintained by a rural electric cooperative or a rural telephone cooperative; or

(5) An employee leasing arrangement.

(j) “Rural electric cooperative” means:

(1) Any organization which is exempt from tax under Section 501 (a) of Title 26 of the United States Code and which is engaged primarily in providing electric service on a mutual or cooperative basis; or

(2) Any organization described in Paragraph (4) or (6) of Section 501 (a) of Title 26 of the United States Code which is exempt from tax under Section 501 (a) of Title 26 and at least eighty percent (80%) of the members of which are organizations described in Paragraph (1) of this subsection.

(k) “Rural telephone cooperative” means an organization described in Paragraph (4) or (6) of Section 501 (c) of Title 26 of the United States Code which is exempt from tax under Section 501 (a) of Title 26 and at least eighty (80%) percent of the members of which are organizations engaged primarily in providing telephone service to rural areas of the United States on a mutual, cooperative or other basis.

(Effective September 25, 1992; amended March 28, 1996)

Sec. 38a-272-4. Producers prohibited from assisting reportable MEWAs prior to filing

(a) No producer may solicit, advertise, or market in this state health benefits or coverage from, or accept an application for, or place coverage for a person who resides in this state with, a reportable MEWA unless the producer first files the information required under Section 38a-272-9.

(b) No producer may solicit another producer to enter into an arrangement to solicit, advertise or market services, health benefits or coverage of a reportable MEWA unless the producer first files the information required under Section 38a-272-9.

(Effective September 25, 1992; amended March 28, 1996)

Sec. 38a-272-5. Producers prohibited from assisting employee leasing arrangements prior to filing

(a) No producer may solicit, advertise or market in this state the services, health benefits or coverage of an employee leasing arrangement or a person or arrangement which represents itself as an employee leasing arrangement unless the producer first files the information required under Section 38a-272-9.

(b) No producer may solicit another producer to enter into an arrangement to solicit, advertise or market the services, health benefits or coverage of an employee leasing arrangement unless the producer first files the information required under Section 38a-272-9.

(Effective September 25, 1992; amended March 28, 1996)

Sec. 38a-272-6. Producers prohibited from assisting collectively bargained arrangements prior to filing

(a) No producer may solicit, advertise, or market in this state health benefits or coverage from, or accept an application for, or place coverage for a person who resides in this state with, a collectively bargained arrangement unless the producer first files the information required under Section 38a-272-9.

(b) No producer may solicit another producer to enter into an arrangement to solicit, advertise or market health benefits or coverage of a collectively bargained arrangement unless the producer first files the information required under Section 38a-272-9.

(Effective September 25, 1992; amended March 28, 1996)

Sec. 38a-272-7. Licensed insurers prohibited from assisting reportable MEWAs prior to filing

(a) No licensed insurer may solicit or effect coverage of, underwrite for, collect charges or premiums for, adjust or settle claims of a resident of this state for, or enter into any agreement to perform any of those functions for a reportable MEWA that provides coverage to residents of this state unless the insurer first files the information required under Section 38a-272-9.

(b) A licensed insurer which issues or has issued any insurance coverage to a reportable MEWA that covers residents of this state, including, but not limited to, a specific aggregate stop-loss coverage, shall file the information required under Section 38a-272-9 within thirty (30) days after the coverage is issued or within thirty (30) days after the date the reportable MEWA first provides coverage to a resident of this state, whichever is later.

(Effective September 25, 1992)

Sec. 38a-272-8. Lack of knowledge not a defense

(a) Lack of knowledge or intent to deceive with respect to the organization or status of insurance coverage of a reportable MEWA, employee leasing firm or collectively bargained arrangement is not a defense to a violation of this regulation.

(b) A filing under this regulation is solely for the purpose of providing information to the commissioner. This regulation and any filing made thereunder do not authorize or license a reportable MEWA, employee leasing firm, collectively bargained arrangement or any other arrangement to engage in business in this state if otherwise prohibited by law.

(Effective September 25, 1992)

Sec. 38a-272-9. Information required to be filed and kept current

(a) A producer or insurer required to file under Sections 38a-272-4 through 38a-272-7 shall file all of the following information on a form prescribed by the Commissioner:

(1) A copy of the organizational documents of the reportable MEWA, employee leasing firm or collectively bargained arrangement, including the articles of incorporation and bylaws, partnership agreement or trust instrument;

(2) A copy of each insurance or reinsurance contract which purports to insure or guarantee all or any portion of benefits or coverage offered by the reportable MEWA, employee leasing firm or collectively bargained arrangement to any person who resides in this state;

(3) Copies of the benefit plan description and other materials intended to be distributed to potential purchasers; and

(4) The names and addresses of any person performing or expected to perform the functions of a third party administrator for the reportable MEWA, employee leasing firm or collectively bargained arrangement.

(b) A filing under this section is ineffective and is not in compliance with this regulation if it is incomplete or inaccurate in any material respect.

(c) A person who has made a filing under this regulation shall amend such filing within thirty (30) days of the date the person becomes aware, or exercising due diligence should have become aware, of any material change to the information required to be filed. The amended filing shall accurately reflect the material changes to the information originally filed.

(d) (1) A reportable MEWA, employee leasing arrangement, or collectively bargained arrangement may voluntarily file with the Commissioner the information specified in Subsection (a) of this section on a form prescribed by the Commissioner, providing the filing is not incomplete or inaccurate in any material respect and is accompanied by a statement signed by an officer of such organization stating that the voluntary filing is made with the understanding that the organization will amend the filing within thirty (30) days of the date of any change to the information required to be filed.

(2) When a filing is made pursuant to Paragraph (1) of this subsection the Commissioner may, in his discretion, elect to exempt producers or insurers from the information filing requirements of this section so long as the provisions of Subsections (b) and (c) of this section are complied with.

(Effective September 25, 1992; amended March 28, 1996)

Sec. 38a-272-10. Liability for violation

In addition to the penalties provided in Section 38a-278 of the General Statutes that may be imposed by the Commissioner, in the event that an arrangement that is an unauthorized insurer fails to pay a claim or loss in this state within the provisions of its contract, any person who shall be assisted or in any manner aided directly or indirectly in the procurement of such insurance contract shall be liable in accordance with Section 38a-275 of the General Statutes to the insured for the full amount of the claim or loss in the manner provided by the provisions of such insurance contract.

(Effective September 25, 1992)

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Insurance on Motor Vehicles Sold Under Instalment Contracts or Pledged for a Loan

Sec. 38a-288-1. Application of regulations

The following regulations shall govern the issuance of insurance on motor vehicles sold under instalment or deferred payment contracts or motor vehicles pledged as security for a loan.

(Effective September 25, 1992)

Sec. 38a-288-2. Description of insurance to purchaser or borrower

There shall be a complete disclosure of insurance obtained by a dealer, finance factor or lender from an insurance company or an authorized agent thereof, which shall be made in all cases to the ultimate purchaser of such insurance, as follows:

(a) In no instance shall the insurance company issue a policy or policies unless a statement setting forth a clear and concise description of the insurance coverage has been furnished to the purchaser or borrower at the time of the sale or loan transaction. The policy or policies, when issued and, within the time limit prescribed by section 42-86 of the general statutes (fifteen days) after execution of a retail instalment sale contract, shall be sent to the purchaser or borrower and shall indicate clearly the amount of the premium, the kind or kinds of insurance and the scope of the coverage and shall contain all of the terms, exceptions, restrictions and conditions of the contract or contracts of insurance.

(b) Policies not containing public liability or property damage coverage shall be clearly stamped or printed to the effect that such coverage is not included in the policy.

(Effective September 25, 1992)

Sec. 38a-288-3. Policy requirements. Records

(a) All policies or certificates of insurance shall be written in strict accordance with the rates and rules filed by or on behalf of the insurance company writing such policies with the insurance department of this state. No coverages shall be written that are not contained in the manuals of insurance legally in effect for use within this state, unless specific approval has been received from the insurance department of this state prior to the sale of such coverage and the issuance of policies therefor.

(b) No contractual agreement or plan shall be used which permits the collection of an application or policywriting fee, in addition to the premium, unless legally in effect.

(c) The insurance company shall at all times maintain complete records of all policies issued, including names and addresses of all insureds and beneficiaries, and the coverage provided, and no plan shall be used that fails to require the soliciting agent to report, and send to the insurance company promptly, all applications for insurance, or copy-dailies of policies issued.

(d) No so-called master policy shall reduce in any manner whatsoever the standard form policy rights of the insured (purchaser or borrower) on similar coverage in this state, as compared to the individual type of policy, with the approved standard loss payable clause attached.

(e) All policies of insurance when issued shall be effective from the moment the purchaser takes delivery of the property insured or the borrower's loan transaction is consummated.

(Effective September 25, 1992)

Sec. 38a-288-4. Term of coverage. Payment of premiums to insurance company

Policies or certificates of insurance shall be written for the full term for which a premium has been charged the purchaser or borrower in connection with financing or effecting of a loan. All premiums collected or charged in a finance transaction shall be paid to the insurance company for whom the premium was collected, within the terms of any applicable contract between the insurance company and the insurance producer handling the transaction.

(Effective September 25, 1992; amended June 26, 1997)

Sec. 38a-288-5. Single interest coverage

Where single interest coverage is written at the expense of the purchaser or borrower in connection with a finance or loan transaction, a clear and concise statement shall be furnished to the purchaser or borrower, advising him that the insurance effected is solely for the interest of the dealer, finance factor or lender, and that no protection thereunder exists for the benefit of the purchaser or borrower. When single interest is written, the insurance company shall not be entitled to recover from the purchaser or borrower the amount of any claim payment made under the policy. Such single interest policies shall be clearly stamped or printed on the title-page "SINGLE INTEREST ONLY NO SUBROGATION."

(Effective September 25, 1992)

Sec. 38a-288-6. Notice of cancellation or change. Cancellation on repossession

The purchaser or borrower shall be promptly notified of any cancellation or change in a policy or certificate, except where cancellation is effected by surrender of the purchaser's or borrower's policy or certificate contract, or through a lost policy receipt, which shall be accompanied by, or have incorporated therein, a signed request from the named assured for cancellation. All notices of cancellation or change shall be effected in the same manner as the cancellation of other types of policies handled by the insurance company, as provided in the policy; the insurance company shall at all times have evidence that notification of a cancellation or change in a policy or certificate has been properly sent to the purchaser or borrower. Where an insured financed unit has been repossessed and the dealer, finance factor or lender certifies to the insurer the facts of such repossession in form satisfactory to the insurer, the insurance company may cancel the policy upon evidence to that effect.

(Effective September 25, 1992)

Sec. 38a-288-7. Cancellation; repayment of unearned premiums

(a) Where a policy is cancelled by the insurance company, the pro rata unearned return premium due shall be paid either directly by the insurance company or credited to the account of the producer through whom the policy was written, with prompt repayment of such unearned premium as may be due the purchaser or borrower being effected by the producer or insurance company. Records of the insurance company and producers shall at all times be available for the inspection of representatives of the insurance department. Where policies are cancelled upon request of the purchaser or borrower, cancellation shall be in accordance with the terms of the policy contract with payment of the unearned premium as herein provided. A fire, theft and collision policy is a divisible contract and the payment of a total loss on one of the coverages gives the insurance company no right to cancel the policy without payment of appropriate return premium on the other coverage or coverages for which separate premiums were collected under the policy.

(b) In the event of a repossession and cancellation, the insurance company shall secure an affidavit of repossession to warrant the cancellation and retention by the dealer, finance factor or lender of the return premium as a credit against the unpaid balance of the purchaser or borrower. In case of cancellation upon prepayment the insurance company shall have unmistakable evidence in its files that the purchaser or borrower has received proper cash return or credit. In no case shall an insurance company pay the return premium to a dealer, finance factor or lender if there is an "overage balance" in the account of the purchaser or borrower. The amount of return premium due shall be shown on all notices of cancellations.

(Effective September 25, 1992; amended June 26, 1997)

Sec. 38a-288-8. Commission payable only to producer

No commission in any form shall be paid or allowed except to a duly licensed producer.

(Effective September 25, 1992; amended June 26, 1997)

Sec. 38a-288-9. Coercion prohibited

Coercion in the placing of insurance is prohibited.

(Effective September 25, 1992)

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Height and Style of Type to be used in Insurance Policies

Sec. 38a-297-1. Authority

This regulation is adopted and promulgated by the Insurance Commissioner pursuant to Section 38a-297 of the General Statutes, as amended by Public Act 81-110.

(Effective September 25, 1992)

Sec. 38a-297-2. Purpose

The purpose of this regulation is to specify minimum letter height and acceptable type-face styles for all policies covered under Chapter 699a.

(Effective September 25, 1992)

Sec. 38a-297-3. Height requirements

(a) Each policy subject to Chapter 699a shall be printed, except for specification pages, schedules and tables, in not less than ten-point type, one-point leaded, provided capital letters shall measure not less than six points.

(b) For purposes of this regulation, one point shall equal 1/72 of an inch.

(Effective September 25, 1992)

Sec. 38a-297-4. Style requirements

(a) The following type-face styles shall be acceptable under this regulation.

Aldus	Chelmsford (Optima)
Alternate Gothic No. 3	Clarendon Light
American Typewriter Light	Clearface
American Typewriter Medium	Crown (Century)
Americana	Egyptian
Andover (Palatino)	Egyptian Light
Antique Olive Light	Electra
Aster	Eurostile
Auriga	Fairfield Medium
Avant Garde Light	Friz Quadrata
Avant Garde Book	Garamond
Baskerville	Garamond No. 3
Bembo	Goudy Oldstyle
Benguiat Book	Hanover (Melior)
Bodoni	Helvetica Light
Bodoni Book	Helvetica
Bookman	Helvetica Condensed
Caledonia	Highland (Caledonia)
Candida	Iridium
Caslon Old Face No. 2	Italia Book
Century Expanded	Janson
Century Schoolbook	Korinna
Megaron Light (Helvetica Light)	Stymie Medium
Megaron Medium (Helvetica Medium)	Stymie Light
Melior	Tiffany Light
Memphis Light	Tiffany Medium
Memphis Medium	Times Roman
Monticello	Trade Gothic Light
News Gothic	Trade Gothic
Optima	Trade Gothic Condensed
Orion	Trade Gothic Extended
Palatino	Trump
Primer	Trump Medieval

Quorum Light	Univers Light
Quorum Book	Univers Medium
Rotation	Univers No. 45
Sabon	Univers No. 46
Schoolbook	Univers No. 55
Serif Gothic Light	Univers No. 56
Souvenir	Univers No. 57
Souvenir Light	Univers 45 Light

This list is not intended to be exhaustive but is intended solely as an indication of the legibility of a type-face style that is required. Any type-face style selected other than those listed above may be used only with the approval of the Insurance Commissioner. Extreme type styles such as “Old English” or heavy block are not acceptable.

(b) Italics, bold face and contrasting styles may be used to emphasize important or technical terms and for captions. When two or more type-face styles are used, they shall be visually compatible.

(Effective September 25, 1992)

Sec. 38a-297-5. Certification

Certification required per Connecticut General Statutes 38a-297 (c) must include a statement that the policy complies with the height requirements of this regulation and must identify the type-face styles used in the policy.

(Effective September 25, 1992)

Sec. 38a-297-6. Applicability

The provisions of this regulation shall apply to all policies covered under Chapter 699a as follows: to all policies filed on or after January 1, 1982, to all individual policies delivered or issued for delivery in this state on or after July 1, 1982 and to all group policies and certificates delivered in this state on or after July 1, 1983.

(Effective September 25, 1992)

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Claims-made Liability Insurance Policies

Sec. 38a-327-1. Definitions

As used in Sections 38a-327-1 to 38a-327-6, inclusive:

(a) “Claims-made policy” means an insurance policy or an endorsement to an insurance policy that covers liability for injury or damage that the insured is legally obligated to pay (including injury or damage occurring prior to the effective date of the policy, but subsequent to the retroactive date, if any), arising out of incidents, acts or omissions, as long as the claim is first made during the policy period or any extended reporting period.

(b) “Claim” means written notice of any act or omission of the insured, or of any incident, alleged to have caused injury or damage that the insured is legally obligated to pay, whether or not constituting a legal complaint.

(c) “Incident” means a specific act, omission, occurrence or circumstance which may reasonably result in a claim.

(d) “Commissioner” means the Insurance Commissioner of the State of Connecticut.

(e) “Retroactive date” means a date concurrent with the effective date of the policy or with the effective date of coverage for a new operation or location added to the policy, or a specified date prior to the effective date of the policy upon which the insurer and insured agree in the policy that coverage will be applicable.

(f) “Additional extended reporting period coverage” means:

(1) For policies described in Section 38a-327-2 (1), (2), (3) and (5), coverage for that period of time specified in the policy wherein claims first made after the termination of coverage under the policy, for acts, errors or omissions that occur on or after the retroactive date, if any, but prior to expiration of the policy term will be considered made during the policy term;

(2) For all other types of policies, coverage for that period of time specified in the policy wherein claims first made after the termination of coverage under the policy, for injury or damage that occurs on or after the retroactive date, if any, but prior to expiration of the policy term will be considered made during the policy term.

(g) “Automatic extended reporting period coverage” means coverage for that period of time specified in the policy wherein claims first made after the termination date of the policy but within thirty (30) days of the termination date of the policy will be considered first made during the policy term.

(h) “Aggregate limit” means the specified maximum limit of liability which shall apply for each [annual] policy term as the total limit for one or more claims.

(i) “Excess liability policy” means any commercial liability policy, other than an excess motor vehicle liability policy, written over: (1) one or more underlying liability policies that in the aggregate provide primary coverage of at least one million dollars (\$1,000,000); or (2) a liability self-insured retention of at least fifteen million dollars (\$15,000,000).

(j) “Termination of coverage” means, whether made by the insurer or the insured at any time: (1) cancellation or nonrenewal of a policy; or (2) decrease in limits, reduction of coverage, increased deductible or self-insured retention, new exclusion, or any other change in coverage less favorable to the insured.

(k) “Named insured” means: (1) the first named insured, with respect to directors and officers liability, employee benefits liability and fiduciary liability policies, and (2) all named insureds, with respect to all other types of claims-made policies.

(Effective September 25, 1992)

Sec. 38a-327-2. Types of coverage of risks

Claims-made coverage may not be provided in any policy delivered, issued for delivery or renewed in this state by a licensed insurer on or after the effective date of this regulation, unless the claims-made policy is issued for one of the following lines, sublines, risks or coverages:

- (1) Directors and Officers Liability;
- (2) Employee Benefits Liability;
- (3) Errors and Omissions Liability;
- (4) Excess Liability;
- (5) Fiduciary Liability;
- (6) Pollution and Environmental Impairment Liability;
- (7) Products and Completed Operations Liability;
- (8) Professional Liability;
- (9) Public Entity Liability; and
- (10) Commercial liability coverage for a large business entity generating gross revenues of at least one hundred million dollars (\$100,000,000) annually, and where such risk develops an annual commercial general liability manual premium on a mature level on a claims-made basis of at least five hundred thousand dollars (\$500,000).
- (11) Coverage for an individual risk or class of insurance based on a request by the insurer when such insurance is not generally available and is submitted to the Insurance Department and is approved by the Commissioner.

(Effective September 25, 1992)

Sec. 38a-327-3. Minimum standards

No claims-made policy shall be delivered, issued for delivery, or renewed in this state by a licensed insurer on or after the effective date of this regulation, unless such policy and the issuing insurer complies with the following minimum standards:

(a) Once a retroactive date is established with an insured, it may be advanced only with the written consent of the named insured. Prior to the advancement of the retroactive date by an insurance company, such insurer must obtain the written acknowledgment of the named insured that the named insured has been advised of the right to purchase the additional extended reporting period coverage. If no retroactive date is specified in the policy, coverage is afforded for injury or damage occurring prior to the inception date of the policy.

(b) Each claims-made policy shall provide an automatic extended reporting period of at least thirty (30) days upon termination of coverage.

(c) A claim will be deemed "first made" when the insurer receives written notice of a claim from the insured or a third party, but this shall not preclude an insurer from utilizing either written notice of incident as the trigger of coverage under the policy.

(d) (1) Additional extended reporting period coverage shall be made available for purchase by the named insured at any time during the policy term and not later than thirty (30) days following termination of coverage, including termination for non-payment of premium. Such additional extended reporting period coverage shall apply only in regard to that coverage terminated, and shall be made available on the same terms and conditions as those specified in the policy.

(2) Where premium is due to the insurer for coverage under the claims-made policy, any monies received by the insurer from the insured as payment for the additional extended reporting period coverage shall be first applied to such premium

owing for the policy. The additional extended reporting period coverage will not take effect until the premium owing for the policy is paid in full and unless the premium owing for the additional extended reporting period coverage is paid promptly when due.

(3) The insurer must advise the named insured in writing of the automatic extended reporting period coverage and the availability of, the premium for, and the importance of purchasing additional extended reporting period coverage. This advice must be sent no earlier than the date of notification of termination of coverage nor later than fifteen (15) days after termination of coverage.

(4) The named insured shall have the greater of thirty (30) days from the effective date of termination of coverage, or fifteen (15) days from the date of mailing or delivery of the advice required by subdivision (3) of this subsection, to submit written acceptance of additional extended reporting period coverage.

(5) The premium charged for additional extended reporting period coverage shall be based upon the rates for such coverage in effect on the later of the date the policy was issued or last renewed, and the insurer shall not charge a different premium for such coverage due to any change in its rates, rating plans or rating rules subsequent to issuance or last renewal of the policy.

(6) Upon termination of a claims-made policy each insurer shall offer additional extended reporting period coverage for at least the following specified durations:

(A) unlimited extended reporting period coverage for professional liability insurance policies;

(B) a minimum one year period for policies covering (i) directors and officers liability, employee benefits liability and fiduciary liability, and (ii) pollution and environmental impairment liability;

(C) a minimum three year period for all other claims-made policies.

(e) Notwithstanding subsection (d) of this section, unlimited additional extended reporting period coverage shall be provided without additional cost to the insured if, while covered by a medical malpractice policy, the insured:

(1) dies;

(2) becomes permanently disabled and is unable to carry out his or her practice; or

(3) retires permanently from practice:

(A) at or over age sixty-five and has been insured with the same insurer on a claims-made basis for a period of at least five consecutive immediately preceding years; or

(B) at or over sixty-two years of age and has been insured with the same insurer on a claims-made basis for a period of at least ten consecutive immediately preceding years.

(f) (1) Where a policy has no aggregate liability limit the insurer shall offer additional extended reporting period coverage without an aggregate liability limit.

(2) Where a policy contains an aggregate liability limit, the insurer shall offer additional extended reporting period coverage with an aggregate liability limit at least equal to the aggregate liability limit specified in such policy.

(g) The minimum standards may be waived if application is made to the Commissioner and he determines that it would improve availability of coverage and not be detrimental to policyholders.

(Effective September 25, 1992)

Sec. 38a-327-4. Disclosure and notice requirement

Every claims-made policy shall contain a notice on the first page of the policy and any certificate in either contrasting color or in boldface type at least equal to

the size of type used for policy captions, conspicuously displayed, stating that the policy is written on a claims-made basis.

(Effective September 25, 1992)

Sec. 38a-327-5. Applicability

This regulation shall apply to every new claims-made policy issued to be effective on or after May 1, 1990 and to every existing claims-made policy renewed to be effective on or after May 1, 1990.

(Effective September 25, 1992)

Sec. 38a-327-6. Separability

If any provision of this regulation 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.

(Effective September 25, 1992)

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Connecticut FAIR Plan

Sec. 38a-328-1. Purpose of program

(a) To make basic insurance available, subject to the conditions hereinafter stated;

(b) To establish a Connecticut FAIR (Fair Access to Insurance Requirements) Plan, and a joint underwriting facility to apportion and distribute risks equitably among insurers in the manner and subject to the conditions hereinafter stated as per Title 38a of the Connecticut General Statutes.

(Effective September 25, 1992)

Sec. 38a-328-2. Effective date

(a) The program shall become effective on September 1, 1969 and as amended thereafter.

(b) The program is intended to conform with the applicable provisions of the Urban Property Protection and Reinsurance Act of 1968, as amended (P.L. 90-448), hereinafter referred to as the "Act," and Connecticut law.

(Effective September 25, 1992)

Sec. 38a-328-3. Definitions

(a) "Insurer" means any insurance company or other organization licensed to write and engaged in writing property insurance business, including the property components of multi-peril policies, or liability coverage. Such liability coverage is limited to those forms of insurance available on the normal voluntary market for single family, two family, three family or seasonal dwellings of not more than three families, on a direct basis, in this state, except where such insurer is specifically exempted from participation in this program.

(b) "Servicing insurer" means (1) the Connecticut FAIR Plan or (2) any insurer who enters into an agreement with the FAIR Plan to issue and service policies on risks referred to it by the FAIR Plan.

(c) "Basic insurance" means coverage against direct loss to real and tangible personal property at a fixed location including insurance against direct loss to property which is being constructed or rehabilitated (builder's risk coverage), that is provided in (1) the standard fire insurance policy of the State of Connecticut, (2) the extended coverage endorsement, and (3) vandalism and malicious mischief and sprinkler leakage insurance, as well as coverage against liability arising from the ownership, maintenance and use of such property. Liability coverage shall be limited to those forms of insurance available on the normal voluntary market, for single family, two family, three family or seasonal dwellings of not more than three families. Upon recommendation of the governing committee and approval of the insurance commissioner, the program may be extended to include such additional lines of insurance as may be designated. Basic insurance does not include automobile, farm, and such types of manufacturing risks as may be excluded by the insurance commissioner.

(d) "FAIR Plan" means an organization formed by insurers to assist applicants in securing basic property insurance.

(e) "Inspection agency" means the organizations designated by the FAIR Plan, filed with the insurance commissioner, to make inspections as required under this program and to perform such other duties as may be authorized by the FAIR Plan.

(f) "Premiums written" means gross direct premiums charged during the preceding calendar year with respect to property in this state on all policies of basic insurance and the basic insurance premium components of all multi-peril policies,

as computed by the FAIR Plan, less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits and also excluding premiums attributable to the operation of the FAIR Plan.

(g) “Commissioner” means the insurance commissioner of the State of Connecticut.

(h) “Manager” means the general manager of the FAIR Plan appointed by the governing committee to perform such duties as the committee may designate.

(Effective September 25, 1992)

Sec. 38a-328-4. Inspection and reports

(a) Any person having an insurable interest in real or tangible personal property at a fixed location shall be entitled to an inspection of the property without cost to the applicant if the FAIR Plan is (1) unwilling to write the coverage at regular rates or (2) declines the application based on the physical condition of the property.

(b) The manner and scope of the inspection of FAIR Plan risks shall be prescribed by the FAIR Plan with the approval of the commissioner.

(c) An inspection report shall be made for each property inspected. The report shall cover pertinent structural and occupancy features as well as the general condition of the building. A representative photograph of the property may be taken during the inspection.

(d) During the inspection, the inspector may point out features of structures and occupancy to the applicant or his representative which may result in condition charges if the risk is accepted. The inspector shall have no authority to advise if the FAIR Plan will provide the coverage.

(e) After inspection, a copy of the completed inspection report, and any photograph, indicating the pertinent features of building, construction, maintenance, occupancy, including any condition charges or surcharges imposed by inspection or under the program, or under any substandard rating plan approved by the commissioner shall be prepared. A copy of the inspection report shall be made available to the applicant or his agent upon request.

(Effective September 25, 1992)

Sec. 38a-328-5. Policy issuance

Upon determination by the FAIR Plan that an applicant is eligible for coverage, or renewal of coverage, and upon receipt by the FAIR Plan of the full amount of the required premium, the FAIR Plan shall issue a binding receipt and/or issue a policy within three working days.

If a condition charge is made the applicant shall be provided with a statement indicating the improvements necessary to remove the charge.

(Effective September 25, 1992)

Sec. 38a-328-6. Assumption of liability

All liability of the FAIR Plan shall be assumed by its participating companies.

(Effective September 25, 1992)

Sec. 38a-328-7. Joint underwriting organization

(a) A joint underwriting organization shall be created consisting of all insurers licensed to write the lines of insurance written by the FAIR Plan. All such insurers shall participate in the FAIR Plan.

(b) Each participating company shall participate in the FAIR Plan’s writings, expenses, profits and losses in the proportion that such member’s premiums written

during the preceding calendar year bears to the aggregate of premiums written by all members of the FAIR Plan.

(Effective September 25, 1992)

Sec. 38a-328-8. Standard policy coverage and limits of liability

(a) All policies issued shall be limited to basic insurance on authorized policy forms and approved amendatory endorsements. Each such policy shall be for a term of one year.

(b) The limit of liability which may be placed through this program is subject to the following special limits per location for construction, protection and class of occupancy:

	Limits
(1) Habitational occupancy classes:	
(A) One, two, three or four family private dwelling building	\$350,000
(B) Household and personal property usual or incidental to the occupancy of each private dwelling unit or each apartment dwelling unit and use therein	75,000
(C) Public liability-one to three family	300,000
(2) All other occupancy classes including commercial, service and manufacturing property with respect to buildings:	
(A) Fire Resistive Construction	1,000,000
(B) Ordinary Masonry Construction	700,000
(C) Frame Construction	500,000
(3) All other occupancy classes with respect to contents:	
(A) Fire Resistant Construction	250,000
(B) Ordinary Masonry Construction	200,000
(C) Frame Construction	200,000

Note: The above content limits may be doubled in the case of sole occupancy.

(c) The foregoing limits may be increased upon approval of the governing committee. In no event shall the total amount of insurance exceed one million five hundred thousand dollars on any single risk. The FAIR Plan will attempt to place insurance up to the full insurable value of the risk to be insured, except to the extent that deductibles, percentage participation clauses and other underwriting devices are employed to meet special problems of insurability.

(d) Policies written pursuant to this program shall be separately coded.

(Effective September 25, 1992; amended July 2, 2003)

Sec. 38a-328-9. Declinations

Applications for coverage shall be declined where the property is determined to be uninsurable because it fails to meet program standards. Such declinations shall be furnished in writing to the applicant with a copy to the commissioner and shall include a statement of the conditions which make the property uninsurable and the measures, if any, which, if taken, would make the property insurable. Such statement shall also inform the applicant of his right to appeal such determination by the FAIR Plan and shall advise him of the means whereby such an appeal may be initiated. Declinations for physical condition must be based on an inspection report.

(Effective September 25, 1992)

Sec. 38a-328-10. Provisional binder. Estimated premium

(a) To prevent lapses of insurance coverage for risks eligible under the program, before coverage has been made available or declined, the insurance requested,

subject to all provisions of this program, will be automatically effective on the twenty-first day following the date the application was received or such later date requested by the insured on the application if:

(1) through no fault of the applicant, coverage has not been either offered or denied within twenty calendar days after the date the request for inspection was received, and

(2) the applicant, at any time prior to the receipt of a report indicating that the property is uninsurable, pays the estimated annual premium.

(b) Manual rates shall be used in developing the estimated annual premium which shall be subject to an appropriate premium adjustment, based on an inspection of the property.

(Effective September 25, 1992)

Sec. 38a-328-11. Program standards

(a) It is the intent of the program to make basic insurance available to applicants who in good faith request coverage for eligible properties which meet program standards.

(b) The occurrence or presence of any of the following conditions constitutes failure to meet program standards and shall provide a basis for declination, cancellation, or non-renewal of an application, binder or policy:

(1) Vacancy or unoccupancy of the property for sixty (60) days or more, other than for rehabilitation purposes, provided however, a building shall not be deemed vacant or unoccupied unless at least 75% of owner occupied family dwellings of not more than three families or at least 65% of any other building is vacant or unoccupied.

(2) Existing substantial damage which the applicant or insured has failed or refused to repair.

(3) Failure to pay real estate taxes on the property for two (2) years or more.

(4) Failure, within the insureds control, to furnish heat, water, or public lighting for 30 days or more.

(5) Failure within a reasonable time to correct conditions dangerous to life, health or safety including but not limited to conditions resulting from overcrowding or excessive rubbish or flammable materials.

(6) As respects commercial properties, failure to provide protective devices required by law.

(7) Conviction of any person with a financial interest in the property of fraud or incendiarism.

(8) Loss history of the applicant. The frequency, severity, circumstances of the loss(s), and the number and value of the properties insured shall be considered. Each declination, non-renewal, or cancellation based on loss history must be subject to approval by the Governing Committee.

(9) Material misrepresentation concerning this insurance or the subject thereof.

(10) Abandonment of the property or removal of heating or plumbing equipment or fixtures.

(11) Non-payment of premium by the insured.

(12) Where the FAIR Plan has received reliable information that the property will be intentionally damaged or destroyed for the purpose of collecting the insurance proceeds.

(13) Buildings on which because of their physical condition there is an outstanding order to vacate, an outstanding demolition order or which have been declared unsafe in accordance with applicable law. Neighborhood or area location or any

environmental hazard beyond the control of the property owner shall not be deemed to be acceptable criteria for declination, cancellation, or non-renewal of a risk.

(Effective September 25, 1992)

Sec. 38a-328-12. Rates

Promptly following each inspection, rates shall be promulgated for each risk in accordance with rating plans filed with the commissioner.

(Effective September 25, 1992)

Sec. 38a-328-13. Declination, non-renewal or cancellation

(a) The FAIR Plan may issue a notice of declination, cancellation or non-renewal based only on the occurrence or presence of any of the conditions or circumstances set forth in Section 38a-328-11 (b) of these regulations.

(b) The FAIR Plan shall send by registered or certified mail or by mail evidenced by a certificate of mailing, or delivered to the named insured at the address shown in the policy, at least sixty (60) days advance notice of its intention not to renew.

(c) Each notice of cancellation or non-renewal shall specify the reason therefore and the FAIR Plan shall give prior written notice as follows:

(1) For each cancellation based on non-payment of premium, 10 days prior written notice.

(2) For each cancellation based on sub-division (1), (7), (10), (12), or (13) of sub-section (b) of Section 38a-328-11, not less than five (5) days prior written notice to the named insured at the address shown on the policy by registered or certified mail.

(3) For each cancellation based on a reason other than sub-division (1) or (2) of Section 38a-328-13 (c), the FAIR Plan shall give notice as required by Section 38a-307 of the Connecticut General Statutes.

(d) Each notice of declination, cancellation or non-renewal shall be accompanied by a statement explaining the applicant or insured's right of appeal to the manager of the FAIR Plan and the procedures that will govern such an appeal.

(Effective September 25, 1992)

Sec. 38a-328-14. Right of appeal

(a) An applicant or insured may appeal any adverse ruling or decision of the Fair Plan to the manager of the Fair Plan, by making written notice of appeal to the manager. Such appeal shall be made within thirty (30) days of the date of the mailing of the adverse ruling or decision of the Fair Plan. The manager of the Fair Plan, shall within fifteen (15) days of receipt of the written notice of appeal, decide the matter under appeal and notify the applicant or insured in writing of his or her decision.

(b) An applicant or insured may appeal the decision of the manager of the Fair Plan to the Insurance Commissioner within thirty (30) days from the date of the mailing of the decision of the Fair Plan manager, in accordance with the Insurance Department Rules of Practice.

(Effective May 25, 1993)

Sec. 38a-328-15. Commissions

Commissions under the program shall be ten percent of the premium which shall include condition charges and shall be paid to the licensed producer designated by the applicant.

(Effective September 25, 1992)

Sec. 38a-328-16. Administration

This program shall be administered by a governing committee (hereinafter referred to as the committee) of the FAIR Plan and operated by a manager appointed by the committee. The committee shall include ex-officio, the insurance commissioner or the commissioner's designee, one representative of each of the following groups and two members selected by the committee and approved by the commissioner:

American Insurance Association or its successor organization

Property Casualty Insurers Association of America or its successor organization

All other stock insurers

All other nonstock insurers

Professional Insurance Agents of Connecticut or its successor organization

Independent Insurance Agents of Connecticut or its successor organization

Not more than one insurer under the same management or ownership shall serve on the committee at the same time. The ex-officio member shall not vote on matters before this committee.

(Effective September 25, 1992; amended August 31, 2006)

Sec. 38a-328-17. Annual and special meetings

(1) There shall be an annual meeting of the insurers on a date fixed by the committee. The four aforementioned associations shall designate or elect their representatives to the committee. The two nonassociation groups of companies represented on the committee as provided in section 38a-328-16 shall elect their respective representatives by majority vote counted on a weighted basis in accordance with each insurer's premiums written and the aggregate premiums written for all insurers in the respective groups of companies. Representatives on the committee shall serve for a period of one year or until successors are elected or designated.

(2) A special meeting may be called at such time and place designated by the committee or upon the written request to the committee of any ten insurers, not more than one of which may be in a group under the same management or ownership.

(3) Twenty days' notice of such annual or special meetings shall be given in writing by the committee to insurers. A majority of the insurers shall constitute a quorum. Voting by proxy shall be permitted. Notice of any meeting shall be accompanied by an agenda for such meeting.

(4) Any matter, including amendment of this program, may be proposed and voted upon by mail, provided such procedure is unanimously authorized by the members of the committee present and voting at any meeting of the committee. If so approved by the committee, notice of any proposal shall be mailed to the insurers not less than twenty days prior to the final date fixed by the committee for voting thereon.

(5) At any regular or special meeting at which the vote of the insurers is or may be required on any proposal, including amendment to the program, or any vote of the insurers which may be taken by mail on any proposal, such votes shall be cast and counted on a weighted basis in accordance with each insurer's premiums written. A proposal shall become effective when approved by at least two-thirds of the votes cast on such weighted basis.

(6) Any amendment of the program shall be subject to approval by the commissioner.

(Effective September 25, 1992; amended August 31, 2006)

Sec. 38a-328-18. Duties of the committee

(a) The committee shall meet as often as may be required to perform the general duties of administration of the program or on the call of the commissioner. Five voting members of the committee shall constitute a quorum.

(b) The committee shall be empowered to appoint a manager, who shall serve at the pleasure of the committee, to budget expenses, levy assessments, disburse funds and perform all other duties provided herein or necessary or incidental to the proper administration of the program.

(c) The manager shall prepare an annual operating budget which shall be subject to approval of the committee.

(d) The committee shall furnish to all insurers and to the commissioner a written report of operations annually in such form and detail as the committee may determine. The FAIR Plan shall submit to the commissioner periodic reports setting forth the number of requests for inspection, the number of risks inspected, the number of risks accepted, the number of risks declined and reinspections made together with such other information as the commissioner may request.

(Effective September 25, 1992; amended August 31, 2006)

Sec. 38a-328-19. Termination of the program

This program shall continue indefinitely but in no event shall be of any force and effect after the expiration of the Urban Property Protection and Reinsurance Act of 1968 and a determination by the commissioner after consultation with the insurance industry that the program is no longer needed, or at such earlier date at which the program provided hereunder shall no longer qualify for riot or civil disorder reinsurance under the Urban Property Protection and Reinsurance Act and the commissioner after consultation with the insurance industry determines that the program is no longer needed. Notwithstanding the foregoing, any obligations incurred by the FAIR Plan shall not be impaired by the expiration of the program and such FAIR Plan shall be continued, for the purpose of performing such obligations.

(Effective September 25, 1992)

Sec. 38a-328-20. Public education

The FAIR Plan will carry on a continuing public education program, in cooperation with participating insurers and producers to assure that the program receives adequate public attention.

(Effective September 25, 1992; amended June 26, 1997)

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Minimum Provisions for Automobile Liability Insurance Policies Covering Motor Vehicles

Sec. 38a-334-1. Required areas of coverage

(a) Policies shall contain at least the following coverages:

- (1) Bodily injury liability and property damage liability;
- (2) protection against uninsured and underinsured motorists as described in section 38a-334-6.

(b) Any policy which, under a separate coverage, undertakes to pay, irrespective of fault, medical expense resulting from bodily injury sustained in motor vehicle accidents, shall provide insurance for medical payments as described in section 38a-334-7.

(Effective September 25, 1992; amended, effective November 1, 2000)

Sec. 38a-334-2. Definitions

As used in sections 38a-334-1 to 38a-334-9, inclusive:

(a) “Bodily injury” means bodily injury, sickness or disease, including death resulting therefrom;

(b) “Motor vehicle” means private passenger motor vehicle as defined in subsection (e) of section 38a-363 of the General Statutes; commercial motor vehicle as defined in section 14-1 of the General Statutes; motorcycle, as defined in section 14-1 of the General Statutes; motor vehicle used to transport passengers for hire, motor vehicle in livery service, as defined in section 13b-101 of the General Statutes; and vanpool vehicle, as defined in section 14-1 of the General Statutes;

(c) “Property damage” means injury to or destruction of tangible property, including loss of use thereof.

(Effective September 25, 1992; amended, effective November 1, 2000)

Sec. 38a-334-3. Language of policies. Presumption re coverage

The provisions herein required need not be stated in the language or form of these regulations, but the coverage afforded shall be of equal or greater benefit to the insured. Policies affording a coverage to which these regulations apply shall be deemed to afford insurance under such coverage at least equal to that required by these regulations.

(Effective September 25, 1992)

Sec. 38a-334-4. Exceptions

These regulations do not apply to the insurance afforded under any policy:

- (1) to the extent that the insurance afforded exceeds the limits specified in subsection (a) of section 14-112 of the General Statutes or
- (2) if the policy contains an underlying insurance requirement or provides for a retained limit of self-insurance equal to or greater than the limits specified in said subsection (a) of section 14-112.

(Effective September 25, 1992; amended, effective November 1, 2000)

Sec. 38a-334-5. Minimum provisions for bodily injury liability and property damage liability

(a) **Coverage.** The insurer shall undertake to pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage caused by accident and arising out of the ownership, maintenance or use of a motor vehicle owned or long-term leased by the named insured. The policy shall designate by explicit description or by appropriate reference the motor vehicles to which this coverage applies.

(b) **Defense, settlement, supplementary payments.** The insurer shall defend the insured against any suit seeking damages covered by the policy, and may make such settlement of any claim or suit as it deems expedient, but the insurer shall not be obligated to defend any suit after the exhaustion of its liability by payment of judgments or settlements. The insurer shall pay, in addition to the policy limits, all expenses incurred by the insurer, premiums on attachment and appeal bonds, court costs, interest on judgments until the insurer has offered to pay its portion of the judgment, the cost of bail bonds, not to exceed one hundred dollars per bond, all expenses incurred by the insured for first aid to others at the time of the accident and other reasonable expenses, other than loss of earnings, incurred by the insured at the insurer's request. The insurer shall, upon request of the named insured, issue or arrange for the issuance of a bond which shall not exceed the aggregate limit of bodily injury coverage for the purpose of obtaining release of an attachment.

(c) **Exclusions.** The insurer's obligation to pay and defend may be made inapplicable:

- (1) To liability assumed under contract;
- (2) to intentionally caused injury or damage;
- (3) to any obligation of the insured to provide workers' compensation or disability benefits or to cover liability of an employer for employee injuries;
- (4) to the use of a motor vehicle as a public or livery conveyance;
- (5) to bodily injury or property damage resulting from the radioactive, toxic explosive or other hazardous properties of source, special nuclear or byproduct material, each as defined in the Atomic Energy Act of 1954, as amended;
- (6) while the private passenger motor vehicle is used for towing a trailer, designed for use with other than a private passenger motor vehicle which is owned or hired by the insured and not covered by like insurance in the same company;
- (7) to damage to property (A) owned or transported by the insured or (B) rented to or in the care, custody or control of the insured or as to which the insured is for any purpose exercising physical control, other than property damage to a residence or private garage by a private passenger motor vehicle covered by this insurance;
- (8) to the operation of a motor vehicle by an individual or individuals specifically named by endorsement accepted by the insured, the form of which has been accepted for filing by the insurance commissioner;
- (9) to liability arising out of pollution or contamination;
- (10) to bodily injury or property damage due to war, whether or not declared, civil war, insurrection, rebellion or revolution, or to any act or condition incident to any of the foregoing;
- (11) to bodily injury or property damage arising out of the ownership, maintenance, use, loading or unloading of any
 - (A) haulaway, tank truck or tank trailer or any automobile used therewith owned, hired or held for sale by the named insured;
 - (B) motor vehicle (i) while being used in any prearranged or organized racing, speed or demolition contest or in any stunting activity or in practice or preparation for any such contest or activity, or
 - (ii) while rented to others by the named insured unless to a salesman for use principally in the business of the named insured, or
 - (iii) while being used by the insured as a public or livery conveyance or for carrying property for a charge.
- (12) To bodily injury to any passenger while occupying a motorcycle.

(d) **Insured.** The insurance afforded shall apply for the benefit of the named insured and any other person or organization using the motor vehicle within the scope of his permission from the named insured, except as follows:

(1) As respects loading or unloading of a motor vehicle, only the named insured, a lessee or borrower of the motor vehicle, or an employee of the named insured or of such lessee or borrower or organization must be an insured;

(2) the insurance as respects any person or organization other than the named insured need not apply:

(A) To any person or organization, or to any agent or employee hereof, employed or otherwise engaged in operating a motor vehicle sales agency, repair shop, service station, storage garage or public parking place with respect to any accident arising out of the maintenance or use of a motor vehicle in connection therewith;

(B) to any employee other than an employee of the named insured with respect to bodily injury sustained by a fellow employee injured in the course of his employment;

(C) (i) to any person other than an employee of the named insured while engaged in the business of his employer with respect to bodily injury to any fellow employee of such person injured in the course of his employment;

(ii) to the owner or lessee (of whom the named insured is a sublessee) of a hired motor vehicle or the owner of a non-owned motor vehicle or any agent or employee of any such owner or lessee;

(iii) to an executive officer of the named insured with respect to a motor vehicle owned by him or by a member of his household;

(iv) to a motor vehicle while used with any trailer owned or hired by such person or organization and not covered by like insurance in the company (except a trailer designed for use with a private passenger motor vehicle and not being used for business purposes with another type motor vehicle), or a trailer while used with any motor vehicle owned or hired by such person or organization and not covered by like insurance in the company;

(D) (i) to a non-owned motor vehicle used in the conduct of any partnership or joint venture of which the insured is a partner or member and which is not designated in this policy as a named insured, or

(ii) if the named insured is a partnership, to a motor vehicle owned by or registered in the name of a partner thereof. The insurance shall apply separately with respect to each insured against whom claim is made or suit is brought, provided the inclusion of more than one insured shall not operate to increase the limits of the insurer's liability.

(e) **Limits of liability.** The limit of the insurer's liability shall not be less than the applicable limits for bodily injury and property damage liability specified in subsection (a) of section 14-112 of the general statutes. Said limits may be stated separately with respect to bodily injury and property damage, or a single limit of liability may be stated, provided it shall not be less than the sum of the separate limits for bodily injury and property damage resulting from any one accident as specified in said subsection (a). The limits may be stated as applicable regardless of the number of insureds, persons or organizations sustaining bodily injury or property damage, claims made or suits brought or motor vehicles to which the policy applies. The insurance for the liability specified in subsection (a) of section 14-112 of the general statutes may be written subject to deductible amounts per claim or per accident, provided an appropriate premium consideration shall be allowed and the deductible provisions shall be clearly stated in the policy and

provided the insurer shall make full payment of all losses regardless of reimbursement by the insured.

(f) **Subrogation.** The insurer shall be subrogated to any rights of recovery of the insured against third parties except as restricted by section 38a-336b of the General Statutes.

(g) **Other insurance.** The policy may provide for proration of loss with other insurance or may provide that insurance for persons or organizations other than the named insured does not apply if such person or organization has other insurance applicable to the loss with limits of liability not less than those specified in subsection (a) of section 14-112 of the General Statutes.

(Effective September 25, 1992; amended, effective November 1, 2000)

Sec. 38a-334-6. Minimum provisions for protection against uninsured or underinsured motorists

(a) **Coverage.** The insurer shall undertake to pay on behalf of the insured all sums which the insured shall be legally entitled to recover as damages from the owner or operator of an uninsured or underinsured motor vehicle because of bodily injury sustained by the insured caused by an accident involving the uninsured or underinsured motor vehicle. This coverage shall insure the occupants of every motor vehicle to which the bodily injury liability coverage applies. "Uninsured motor vehicle" includes a motor vehicle insured against liability by an insurer that is or becomes insolvent.

(b) **Arbitration.** The insurance may provide but not require that the issues of liability as between the insured and the uninsured or underinsured motorist, and the amount of damages, be arbitrated. The insurer may provide against being bound by any judgment against the uninsured or underinsured motorist.

(c) **Exclusions.** The insurer's obligations to pay may be made inapplicable:

(1) To any claim which has been settled with the uninsured motorist without the consent of the insurer;

(2) if the uninsured or underinsured motor vehicle is owned by

(A) the named insured or any relative who is a resident of the same household or is furnished for the regular use of any of the foregoing,

(B) a self insurer under any motor vehicle law, or

(C) any government or agency thereof;

(3) to pay or reimburse for workers' compensation or disability benefits.

(d) **Limits of liability.**

(1) The limit of the insurer's liability may not be less than the applicable limits for bodily injury liability specified in subsection (a) of section 14-112 of the general statutes, except that the policy may provide for the reduction of limits to the extent that damages have been

(A) paid by or on behalf of any person responsible for the injury,

(B) paid or are payable under any workers' compensation law, or

(C) paid under the policy in settlement of a liability claim.

(2) The policy may also provide that any direct indemnity for medical expense paid or payable under the policy will reduce the damages which the insured may recover under this coverage.

(3) Any payment under these coverages shall reduce the company's obligation under the bodily injury liability coverage to the extent of the payment.

(4) This subsection shall not apply to underinsured motorist conversion coverage except that no payment under a policy providing underinsured motorist conversion coverage shall duplicate payment from any other source.

(e) **Recovery over.** With respect to uninsured motorist coverage, the insurer may require the insured to hold in trust all rights against third parties or to exercise such rights after the insurer has paid any claim, provided that the insurer shall not acquire by assignment, prior to settlement or judgment, its insured's right of action to recover for bodily injury from any third party.

(Effective September 25, 1992; amended, effective November 1, 2000)

Sec. 38a-334-7. Minimum provisions for medical payments

(a) **Coverage.** The insurer may undertake to pay reasonable medical expense incurred within one year from the date of the accident for persons who sustain bodily injury while occupying a motor vehicle designated as the subject of the coverage by specific description or appropriate reference.

(b) **Exclusions.** The insurer's obligation to pay may be made inapplicable:

(1) To injury to any person while he is employed or otherwise engaged in the business or occupation of selling, servicing, repairing, parking or storing motor vehicles;

(2) to injury resulting from insurrection, rebellion, revolution or war;

(3) to employees of any insured injured in the course of their employment;

(4) to the use of a motor vehicle as a public or livery conveyance or while located for use as a residence or premises;

(5) to bodily injury resulting from the radioactive, toxic, explosive or other hazardous properties of source, special nuclear or byproduct material, each as defined in the Atomic Energy Act of 1954, as amended;

(6) to injury arising out of the use of

(i) a farm-type tractor or other equipment designed for use principally off public roads, while not upon public roads,

(ii) a vehicle operated on rails or crawltreads, or

(iii) a vehicle while located for use as a residence or premises.

(c) **Non-duplicating provisions.**

(1) The insurer may provide for proration of benefits with other motor vehicle medical payments insurance but for policies effective on or after November 1, 2000, coverage provided pursuant to this section shall be primary over any amount of other health insurance as defined in section 38a-469 of the General Statutes, or any other health coverage, including but not limited to employee welfare plans subject to the Federal Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq., health care plans provided by collectively bargained arrangements, health care plans provided for employees of the United States government and their dependents, part A or part B of Title XVIII of the Social Security Act, Title XIX of the Social Security Act, medical care programs of the Indian Health Service or of a tribal organization and policies issued by the Health Reinsurance Organization;

(2) a provision offsetting the amount paid for medical expenses against any amount payable under the bodily injury liability coverage of the policy may be included;

(3) a provision for subrogation or a lien upon any recovery from a person legally responsible for the injury may be included;

(4) the insurance may be written subject to a deductible stated as a dollar amount provided an appropriate reduction in the rate shall be made in the premium structure; and

(5) in no event shall the total amount of recovery for medical expenses from all sources exceed the total of the insured's medical expenses for bodily injury sustained while occupying a motor vehicle.

(Effective September 25, 1992; amended, effective November 1, 2000)

Sec. 38a-334-8. General provisions

(a) **Policy period: Territory.** Policies shall provide coverage during the period the policy is in effect and within the territorial limits of the United States and Canada or, as regards private passenger automobiles only, between ports thereof.

(b) **Conditions.** (1) A policy may contain in substance the following conditions:

(A) A provision relating to the computation and payment of premium;

(B) a provision that written notice of accident, claim or suit is required; and that copies of any demand or legal process against the insured, the insurer or any third party shall be forwarded immediately to the insurer;

(C) a provision requiring a claimant to benefits under medical payments or protection against uninsured and underinsured motorists coverage to submit to the insurer written proof of claim, and requiring the injured person to submit to physical examinations and to furnish medical reports and records;

(D) a provision requiring the insured to assist and cooperate with the insurer;

(E) a provision that no action shall lie against the insurer until all the terms of the policy have been complied with or, under the liability coverages, until the amount of the insured's obligation to pay shall have been finally determined either by judgment against the insured after actual trial or by written agreement of the insured, the claimant and the insurer, and a further provision that the insurer shall not be joined or impleaded in any action against the insured brought to determine his liability;

(F) a provision that the insurer's consent is necessary to any assignment of interest under the policy;

(G) a provision that the insurer issues the policy in reliance upon the declarations of the named insured and that the policy contains all agreements between the named insured and the insurer and any of its agents relating to the insurance;

(H) a provision relating to the insurer's own method of doing business.

(2) A policy must contain in substance the following conditions:

(A) a provision that bankruptcy or insolvency of the insured shall not relieve the insurer of its obligations under the policy;

(B) a provision that the terms of the policy may not be waived or changed except as stated in the policy;

(C) a provision in a policy as defined in section 38a-341 of the General Statutes limiting the company's rights to terminate insurance on private passenger motor vehicles as provided under section 38a-323, and sections 38a-341 through 38a-346 of the General Statutes.

(Effective September 25, 1992; amended, effective November 1, 2000)

Sec. 38a-334-9. Statutory references

All references in sections 38a-334-1 to 38a-334-8, inclusive, of the Regulations of Connecticut State Agencies to sections of the General Statutes of Connecticut shall mean and include the statutory provision in effect on the date these regulations become effective and as the statutory provision may be thereafter amended from time to time.

(Effective September 25, 1992; amended, effective November 1, 2000)

Sec. 38a-334-10. Effective date

The amendments to Sections 38a-334-1, 38a-334-2, 38a-334-4; Subsections (f) through (g) inclusive of Section 38a-334-5; and Sections 38a-334-6, 38a-334-7, 38a-334-8 and 38a-334-9 of the Regulations of Connecticut State Agencies shall take effect November 1, 2000.

(Adopted effective November 1, 2000)

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Connecticut Motor Vehicle Insurance Safe Driver Classification Plan

Sec. 38a-347-1. Safe driver classification plan form

For all policies (new and renewals), issued to be effective on or after January 1, 1973, each company shall add a rating information form or other policy attachment explaining how its safe driver classification plan operates. This form shall be approved by the insurance commissioner prior to its use.

(Effective September 25, 1992)

Sec. 38a-347-2. Request for review

Upon the request of an insured, the Insurance Commissioner or a person employed in the Insurance Department designated by the Commissioner shall review an insurance company's action in assigning a point or points under any safe driver classification plan. As part of the review, the Insurance Commissioner or his designee shall determine whether the action of the insurance company in assigning a point or points is consistent with the terms of the plan and the provisions of Chapter 682a of the General Statutes of Connecticut. "Point" or "points" includes those assessed for accidents or convictions or both under the Connecticut Automobile Insurance Plan.

(Effective September 25, 1992)

Sec. 38a-347-3. Effective date

Effective October 1, 1975, all forms and policy attachments required by the provisions of § 38a-347-1 of these regulations shall include a direct quotation of § 38a-347-2 of these regulations.

(Effective September 25, 1992)

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Reports to the National Insurance Crime Bureau

Sec. 38a-357-1. Purpose

The purpose of sections 38a-357-1 to 38a-357-8, inclusive of the regulations of Connecticut State Agencies, is to designate the National Insurance Crime Bureau as the central index reporting bureau; to provide for the reporting by insurance companies of motor vehicle total losses due to theft or larceny, or constructive total losses due to fire, of any motor vehicle, or theft of any of its component parts, and other information; and to establish procedures for the payment of costs of administration and operation of a central index file maintained by the National Insurance Crime Bureau.

(Effective September 25, 1992; amended June 26, 1997)

Sec. 38a-357-2. Definitions

As used in Section 38a-357-1 to 38a-357-8, inclusive of the Regulations of Connecticut State Agencies:

(a) “Central Index Reporting Bureau” or “Central Organization” means the National Insurance Crime Bureau (NICB).

(b) “Commissioner” means the insurance commissioner of this State.

(c) “Component Part” means any major part of a motor vehicle, other than a tire, having a manufacturer’s identification number or other unique identifier issued in accordance with the laws of this or any other state, jurisdiction, or country.

(d) “Constructive Total Loss” means the cost to repair and/or the cost to salvage damaged property equals or exceeds the total value of the property at the time of loss.

(e) “Fraud” means a false representation of a matter of fact, by words or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed, which deceives and is intended to deceive an insurer in order to induce it to part with property or surrender some legal right.

(f) “Fraudulent” means characterized, based on, or committed by fraud.

(g) “Fraudulent Act” means action or inaction characterized, based on, or committed by fraud.

(h) “Insurer” means a corporation, company, partnership, association, society, order, individual, or combination of individuals engaged in the business of comprehensive or other insurance.

(i) “Motor Vehicle” means every device in, upon, or by which any person or property is or may be transported or drawn upon a highway, including every vehicle which is self-propelled, except devices propelled or drawn by human power and devices used exclusively upon stationary rails or tracks.

(Effective September 25, 1992; amended June 26, 1997)

Sec. 38a-357-3. Designation

The Commissioner designates the National Insurance Crime Bureau (NICB) as the Central Index Reporting Bureau in the State of Connecticut.

(Effective September 25, 1992; amended June 26, 1997)

Sec. 38a-357-4. Responsibilities of central organization

The responsibilities of the NICB as the Central Organization are as follows:

(a) The NICB shall establish and keep a central index file in a manner to be determined by it and consistent with its established operation procedures for all total losses due to theft or larceny, or total losses due to fire, of any motor vehicle, or theft of any of its component parts reported by insurers. Such reports shall be kept for a minimum of five years from the date of entry into the NICB system,

except in the case of fires and motor vehicle salvage, which will be kept a minimum of two years from such entry.

(b) The NICB shall send acknowledgment of a total theft loss report received from an insurer within 5 working days.

(c) The NICB shall cooperate with insurers in the resolution of errors and the investigation of claims suspected to be fraudulent.

(Effective September 25, 1992; amended June 26, 1997)

Sec. 38a-357-5. Responsibilities of insurers

The responsibilities of insurers are as follows:

(a) Insurers shall report all total losses due to theft or larceny, or constructive total losses due to fire, of any motor vehicle, or theft of any of its component parts, to the NICB within 2 working days from the receipt of sufficient information from the insured. If the insurer has not received an acknowledgment or other communication from the NICB within 10 working days following the submission of a total theft loss report to the NICB, the insurer shall immediately communicate with the NICB to determine the status of the report.

(b) Insurers shall report to NICB all constructive total losses involving motor vehicle salvage, regardless of the nature or cause of loss or the type of coverage involved, including salvage retained by either an insured or a third party claimant. Reports of salvage shall be submitted to NICB within 5 working days of the sale of a salvaged motor vehicle, or within 5 working days after the date of loss payment where an insured or claimant retains possession of a salvaged motor vehicle.

(c) It shall not be deemed to be an unfair claim settlement practice for an insurer to temporarily defer the processing and payments of a claim filed under comprehensive or other coverage in accordance with the following rules:

(1) If the NICB indicates in its response to the insurer that coverage is in effect by more than one insurer for the same motor vehicle, that the motor vehicle has been previously reported as stolen and unrecovered, or that previous similar claims on the same motor vehicle have been reported, the insurer shall promptly investigate and resolve such discrepancy.

(2) If the NICB discovers an erroneous motor vehicle identification number (VIN) and the NICB is unable to clear up such discrepancy internally, it shall send a questionnaire to the insurer. This questionnaire shall be returned to the NICB within 5 working days of receipt by the insurer. If the NICB and the insurer are unsuccessful in resolving the VIN error after a 30-day period from the date of the receipt by the insurer of sufficient information from the insured, the insurer shall proceed with the processing of the loss claim.

(3) If the NICB indicates in its response to the insurer or the insurer finds that it has cause to believe that the claim may have been based on the fraudulent act of any person, the insurer shall promptly provide such information to the NICB and shall cooperate fully with the NICB in the investigation of any such claim.

(Effective September 25, 1992; amended June 26, 1997)

Sec. 38a-357-6. Costs of administration

The NICB is hereby authorized to make assessments, in such manner as its Governing Board may determine, among insurers licensed in the State of Connecticut, to reimburse NICB for the costs of the performance of its duties under sections 38a-357-1 to 38a-357-8, inclusive of the Regulations of Connecticut State Agencies. Such assessments shall be prorated upon the basis of net fire and theft premiums,

including those fire and theft premiums written under comprehensive policies, allocated to the State of Connecticut on the basis of ownership, use or maintenance of motor vehicles. Each insurer which is a member of the NICB shall be entitled to a credit against the assessments authorized in this section for all assessments directly related to Connecticut premiums paid by it to the NICB on account of its membership during the period covered by the assessment.

(Effective September 25, 1992; amended June 26, 1997)

Sec. 38a-357-7. Reporting requirements

All insurers required to submit reports to the NICB for the purpose of complying with sections 38a-357-1 to 38a-357-8 of the Regulations of Connecticut State Agencies, inclusive, shall be bound by all of the reporting requirements of the NICB.

(Effective September 25, 1992; amended June 26, 1997)

Sec. 38a-357-8. Cooperation with NICB

(a) Insurers shall cooperate with the NICB and shall release information in their possession to the NICB upon its reasonable request.

(b) The NICB, in furnishing information to an employee of the Department of Public Safety, Department of Motor Vehicles, a local police department or other law enforcement agency, upon such employee's request, shall do so on behalf of any insurer which reported any such information to NICB.

(Effective September 25, 1992; amended June 26, 1997)

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Connecticut Motor Vehicle Insurance

Sec. 38a-372-1. Certification of security by the individual insurance companies

A form shall be filed with the Insurance Commissioner for the certification of security by the individual insurance companies as required under Section 38a-371 of the Connecticut General Statutes. "Security" means: Bodily Injury Liability (\$20,000 per person, \$40,000 per accident), Property Damage Liability (\$10,000 per accident), and Uninsured and Underinsured Motorist Coverage (\$20,000 per person, \$40,000 per accident).

The following is the approved form which shall be signed by an appropriate official of the company:

CERTIFICATION

The _____ of _____
 (Company) (Address)

hereby certifies that any automobile liability policy issued by said company with respect to a private passenger motor vehicle as to which the owner is required to maintain security under Section 38a-371 of the Connecticut General Statutes, shall be deemed to provide the security required by such statute.

(Name)

 (Title)

 (Signature)

(Effective September 25, 1992; amended March 28, 1996)

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Repealed 38a-374-1—38a-374-2

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Secs. 38a-374-1—38a-374-2.

Repealed, March 28, 1996.

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Repealed 38a-383-1

Connecticut Motor Vehicle Insurance

Sec. 38a-383-1.

Repealed, March 28, 1996.

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Connecticut Motor Vehicle Insurance

Repealed 38a-386-1

Connecticut Motor Vehicle Insurance

Sec. 38a-386-1.

Repealed March 28, 1996.

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Repealed 38a-387-1

Connecticut Motor Vehicle Insurance

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Professional Liability Insurance

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**Title Insurance Coverage:
Real Property Subject to Indian Land Claims**

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**Title Insurance Coverage:
Real Property Subject to Indian Land Claims**

Sec. 38a-424a-1. Purpose

Sections 38a-424a-1 to 38a-424a-4, inclusive, are intended to provide guidelines to maximize the availability of title insurance coverage with respect to real property that is the subject of an Indian land claim consistent with the operation of title insurers on a safe and sound financial basis. Nothing in sections 38a-424a-1 to 38a-424a-4, inclusive, is intended to prohibit title insurers from providing coverage on a basis more favorable to the insured.

(Effective December 22, 1994)

Sec. 38a-424a-2. Definitions

As used in Sections 38a-424a-1 to 38a-424a-4, inclusive:

(1) "Commissioner" means the Insurance Commissioner of the State of Connecticut.

(2) "Exception" or "Indian land claim exception" means the reference to or identification of an Indian land claim lawsuit or notice of intent to sue appearing in Schedule B of the title insurance policy.

(3) "Indian land claim" means a claim for real property or monetary damages based on an alleged illegal transfer, use or occupation of such real property and which claim is based on a violation of any condition or restriction established by common law, statute or other governmental enactment on alienation of lands owned by Native American Indians or Native American Indian tribes.

(4) "Non-residential real property" means vacant unimproved real property, real property with improvements other than a one-to-four family residence, or a non-residential unit in a common interest community.

(5) "Notice of intent to sue" means a written declaration provided to or filed with any municipal government official giving notice that the party filing such notice intends to pursue an Indian land claim and providing a general description of the real property affected which declaration is actually known to the title insurer or recorded in the land records of the municipality affected.

(6) "Residential real property" means real property with improvements consisting only of a one-to-four family residence, including a residential unit in a common interest community.

(7) "Title insurer" means a company organized under laws of this State for the purpose of transacting, as insurer, the business of title insurance and any foreign or alien title insurer engaged in this State in the business of title insurance as insurer.

(Effective December 22, 1994)

Sec. 38a-424a-3. Required practices

(a) **Existing owner's policy—sale or mortgage.** If the real property has been identified in an Indian land claim lawsuit which has been filed in court, or is the subject of a notice of intent to sue, and an owner's policy has been issued by the title insurer to the present owner, the title insurer, upon payment of the appropriate premium, shall issue a new owner's policy to a bonafide purchaser of that real property and a new loan policy to that purchaser's mortgagee taking the Indian land claim exception contained in subsection (e) of this section. If the amount of insurance coverage requested exceeds that under the existing policy the title insurer may limit any loss or damage to the insured by reason of an Indian land claim to the amount of the existing policy.

(b) **Existing loan policy—refinancing.** If the real property has been identified in an Indian land claim lawsuit which has been filed in court, or is the subject of a notice of intent to sue, and a loan policy has been issued by the title insurer to the present mortgagee, the title insurer, upon payment of the appropriate premium, shall issue a new loan policy to the lender taking the Indian land claim exception contained in subsection (e) of this section. If the amount of insurance coverage requested exceeds that under the existing policy, the title insurer may limit any loss or damage to the insured by reason of an Indian land claim to the original amount of the existing loan policy.

(c) **Existing loan policy—foreclosure or deep-in-lieu-of-foreclosure.** If the real property has been identified in an Indian land claim lawsuit which has been filed in court, or is the subject of a notice of intent to sue, and a loan policy is held by the foreclosing lender, the title insurer that issued such policy, upon payment of the appropriate premium, shall issue an owner's policy to the mortgagee named in the loan policy or to the transferee of such mortgagee when title to such real property has become absolute in the mortgagee or its transferee by virtue of a judgment of strict foreclosure or of a deed in lieu of foreclosure from the mortgagor taking the Indian land claim exception contained in subsection (e) of this section. If the amount of insurance coverage requested exceeds that under the existing policy the title insurer may limit any loss or damage to the insured by reason of an Indian land claim to the original amount of the existing loan policy.

(d) **Waiver requirement.** As a condition to the issuance of a policy pursuant to subsections (a), (b) and (c) of this section, the title insurer may require the insured under the existing policy to waive or relinquish any right to file a claim under the existing policy concerning any Indian land claims.

(e) **No reduction in new policy due to pending Indian land claim or notice of intent to sue.** A title insurer may take an exception in any policy issued pursuant to subsection (a), (b) or (c) of this section for the pendency of any Indian land claim lawsuit or notice of intent to sue which identifies, describes or includes the property insured by such policy, provided that no such exception shall operate to reduce the scope and level of coverage below that which was provided in the policy being replaced.

(f) **No existing owner's or loan policy—sale/refinancing.**

(1) If the real property has been identified in an Indian land claim lawsuit which has been filed in court, a title insurer who is not currently the insurer of the property shall issue a policy to a bona fide purchaser or bona fide mortgagee upon payment of the premium, provided that said policy may make exception for any Indian land claim.

(2) If real property is not subject to an Indian land claim lawsuit which has been filed in court but is located in an area subject to a notice of intent to sue, a title insurer who is not currently the insurer of the property shall issue a title insurance policy to a bona fide purchaser or bona fide mortgagee which may make exception for any Indian land claim but shall provide affirmative coverage against actual loss or damage resulting from a final judgment rendered against the insured in any Indian land claim action. The title insurer shall also defend the insured in any Indian land claim lawsuit commenced after the issuance of the policy and shall pay all costs of such defense including court costs, attorney's fees and expenses, all to the extent provided in the conditions and stipulations of the policy.

(3) Coverage for Indian land claims under this section for non-residential real property may be limited to \$500,000 if reinsurance coverage is unobtainable from the title insurer's existing reinsurer in the normal course of business.

(Effective December 22, 1994)

Sec. 38a-424a-4. Underwriting guidelines

Title insurers shall, immediately upon the effective date of sections 38a-424a-1 to 38a-424a-4, inclusive, file with the Commissioner all underwriting guidelines relating to title insurance coverage covering Indian land claims. No changes to such guidelines adopted after the effective date of sections 38a-424a-1 to 38a-424a-4, inclusive, shall be effective until filed with the Commissioner.

(Effective December 22, 1994)

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Approval of Form of Life Insurance and Annuity Policies and Contracts

Sec. 38a-430-1. Definitions

As used in this regulation:

- (a) “Commissioner” means the Insurance Commissioner of this state.
- (b) “Form” means a life insurance or annuity policy or contract, or application, certificate, rider or endorsement used in connection therewith.
- (c) “Insurer” means an insurance company licensed by the Commissioner to write life insurance or annuities.

(Effective September 25, 1992)

Sec. 38a-430-2. Filing procedure

Any insurer required pursuant to Section 38a-430 of the General Statutes to file a copy of a form with the Commissioner for approval, shall comply with the following standards:

(a) **Filing Transmittal Letter.**

(1) The filing transmittal letter should be sent to the attention of the Life and Health Division of the Insurance Department.

(2) If one or more elements within a filing vary by member company within a group of companies, the filer shall send a separate filing transmittal letter for each insurer within the group.

(3) The filer shall enclose a return copy of the transmittal letter(s) along with a stamped self-addressed return envelope of a size sufficient to return the duplicate copies of the filing to the insurer, and one letter size self-addressed stamped envelope to provide the notice required by Section 38a-430-3 (a).

(4) The filing transmittal letter shall contain a descriptive caption. The caption shall identify the insurer when the insurer is a member of an affiliated group of insurers using generic letterhead. The caption shall also include a brief description of the type of filing, and any applicable form identification number. All subsequent correspondence to the Insurance Department on the filing shall include the caption in the identical format as it was displayed in the original filing transmittal letter, in addition to the date of the original filing transmittal letter (and the Department’s file number, if known).

(5) The body of the filing transmittal letter shall list the documents submitted therewith, briefly outline proposed changes, the approval sought, and specify the proposed effective date. When the form sought to be approved by the Commissioner is not subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, the filing transmittal letter shall disclose such fact.

(6) The insurer shall provide in the filing transmittal letter a telephone number for readily contacting the person responsible for submitting the filing.

(b) All forms filed with the Insurance Department in accordance with this section shall be filed in duplicate. All such filings must be submitted in a clearly legible condition.

(c) All form filings shall include a separate document for the disclosure of the intended use of the form and the method it will be marketed. Such disclosure document, which will delimit the scope of the Commissioner’s approval of the form, shall contain in numerical sequence the following:

(1) Information on exactly how the form will be marketed (i.e. individual basis, mass merchandised, association membership, union membership etc.);

(2) The market for which the form is intended (especially note markets such as over age 65, key men, professionals, etc.);

(3) The underwriting basis used, note especially any deviation from standard underwriting rules (medical, non-medical, guaranteed issue, simplified application, etc.);

(4) Any limitation of the use of the form by certain agents or brokers;

(5) An explanation of any change in benefits which occur while the contract is in force with a reference to the contract provisions which relate to the benefit change;

(6) For individual forms, disclosure of whether the commissions and gross premium rates are consistent with those of the company's individual policies. If the assumptions underlying the premium rates differ from the insurer's regular individual policies, an explanation shall be given of the difference, and the reason that use of the form does not result in unfair discrimination;

(7) A notation and explanation of any deviation from the insurer's usual retention; and

(8) Any additional information which may be necessary to completely understand the form and its use in this state.

(d) Every form filing shall be completed in "John Doe" fashion.

(e) (1) Every form filing subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, shall be accompanied with a certificate signed by an officer of the insurer, that the form complies with the Insurance Plain Language Act.

(2) The certificate required by subdivision (1) of this subsection shall be in the following form:

(NAME OF COMPANY)

(COMPANY ADDRESS)

This is to certify that the forms listed below are in compliance with Chapter 699a of the Connecticut General Statutes.

A. Option Selected

_____ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____ .

_____ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:

Form	Form Number	Flesch Score
------	-------------	--------------

B. Test Option Selected

_____ 1. Test was applied to entire policy form(s)

_____ 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. Standards for Certification

A checked block indicates the standard has been achieved.

_____ 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

_____ 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)

_____ 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

_____ 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.

_____ 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

_____ 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsement or riders.

_____ 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

(COMPANY NAME)

(Date)

By: _____
(Title)

(f) Each form filing other than those involving group life, group annuities and group accident and health insurance, shall be accompanied with the rates that will be used in connection with such form.

(g) When an insurer makes reference to another document in its filing, it must include a copy and fully disclose the referenced document.

(h) The Insurance Department is obligated to collect, pursuant to Section 12-211 of the General Statutes, form filing fees from foreign or alien insurers, if the state or foreign country in which they are domiciled imposes such (and larger) fees upon Connecticut's domestic insurers. Accordingly, each insurer domiciled in any other state or jurisdiction which requires such fees shall remit the equivalent filing fee (in the form of a check made payable to the Treasurer, State of Connecticut) together with each such filing submitted. The insurer shall also represent and certify that the fee payment remitted is the same amount required by its domiciliary state or jurisdiction.

(Effective September 25, 1992)

Sec. 38a-430-3. Policy form approval

(a) Within fifteen (15) days of receipt of a form filed with the Commissioner for approval pursuant to Section 38a-430 of the General Statutes, the Insurance Department shall determine a filing to be complete or deficient for purposes of submission for review and shall issue written notice to the insurer regarding the status of the form.

(1) The written notice for a complete filing shall state that the form filing is complete and accepted for filing for review as of the date of its receipt. For purposes of this section, a form filing is complete upon agency determination that it is in compliance with Section 38a-430-2.

(2) The written notice for a deficient filing shall state that the form filing is deficient and not accepted for filing and shall set out the specific items that must be corrected to make the form complete. In addition to this notice, the Insurance Department may notify the insurer, in any manner, of problems with the form.

(b) Unless otherwise provided by law, the Insurance Department shall review all forms filed with the Insurance Commissioner for approval pursuant to Section 38a-430 of the General Statutes in the order in which they are received by the Department; provided, however, that in appropriate circumstances the Commissioner may waive this requirement and direct the immediate review of a form filing. The Department

shall employ a chronological logging system to facilitate the chronological review of such forms.

(c) Within seventy-five (75) days after a form is accepted for review, the Insurance Department shall review the form and either approve it or disapprove it. If, upon such review of the form, the Insurance Department determines that additional information from the insurer is necessary in order to ascertain whether the form is contrary to law or is unfair, deceptive or may encourage misrepresentation of the policy, the Department shall make such request to the insurer. The insurer will then have thirty (30) days from the date of the request to provide the Department with the additional information; provided that during such time, the insurer may request in writing that the period for responding to the request for information be extended for an additional period of time, not to exceed sixty (60) days. The request for extension shall be considered granted upon its receipt by the Insurance Department. During the pendency of the Insurance Department's request for information, the seventy-five (75) day period for Department action shall be tolled. If the insurer fails to comply with such request within the allotted time, the insurer shall be deemed to have voluntarily withdrawn its filing and the Department shall close its file without further action.

(d) The Commissioner shall issue an order disapproving the use of any such form if it does not comply with the requirements of law, or if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy. Any such order shall specify the reason for disapproval of the form.

(e) Forms that are approved by the Commissioner shall have the form and the extra copy of the filing transmittal letter stamped "Approved," together with the name and signature of the staff member who acted upon the filing and the date of the approval.

(Effective September 25, 1992)

Sec. 38a-430-3a. Electronic filing

(a) Any insurer filing a copy of a form with the commissioner in accordance with section 38a-430-2 of the Regulations of Connecticut State Agencies may submit such form electronically using software known as the System for Electronic Rate and Form Filing (SERFF), Version 2.0 or higher, or any subsequent corresponding system, adopted by the National Association of Insurance Commissioners. All such filings shall include the information required in section 38a-430-2 of the Regulations of Connecticut State Agencies.

(b) Filings made electronically shall be considered received by the commissioner when received at the Insurance Department. Filings received on a weekend or legal holiday shall be deemed received on the next business day. An electronic communication from the Insurance Department concerning a filing shall be deemed received by the person to whom the communication is addressed when the communication is sent to that person.

(Adopted effective January 2, 2002)

Sec. 38a-430-4. Severability

If any provision of this regulation or 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.

(Effective September 25, 1992)

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Suitability in Annuity Transactions

Sec. 38a-432a-1. Purpose

(a) The purpose of sections 38a-432a-1 to 38a-432a-8, inclusive, of the Regulations of Connecticut State Agencies is to require insurers to establish a system to supervise recommendations and to set forth standards and procedures for recommendations to consumers that result in transactions involving annuity products so that the insurance needs and financial objectives of consumers known at the time of the transaction are appropriately addressed.

(b) Nothing herein shall be construed to create or imply a private cause of action for a violation of section 38a-432a-1 to 38a-432a-8, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective August 4, 2005; amended November 10, 2008, February 18, 2012)

Sec. 38a-432a-2. Scope

Sections 38a-432a-1 to 38a-432a-8, inclusive, of the Regulations of Connecticut State Agencies shall apply to any recommendation to purchase, exchange or replace an annuity made to a consumer by an insurance producer, or an insurer where no producer is involved, that results in the purchase, exchange or replacement recommended.

(Adopted effective August 4, 2005; amended November 10, 2008, February 18, 2012)

Sec. 38a-432a-3. Exemptions

Unless otherwise specifically included, sections 38a-432a-1 to 38a-432a-8, inclusive, of the Regulations of Connecticut State Agencies shall not apply to transactions involving:

(1) direct response solicitations where there is no recommendation based on information collected from the consumer pursuant to section 38a-432a-1 to 38a-432a-8, inclusive, of the Regulations of Connecticut State Agencies, or

(2) contracts used to fund:

(A) an employee pension or welfare benefit plan that is covered by the federal Employee Retirement and Income Security Act (ERISA), Public Law 93-406;

(B) a plan described by the following sections of the federal Internal Revenue Code: 26 USC 401(a), 26 USC 401(k), 26 USC 403(b), 26 USC 408(k), or 26 USC 408(p), if established or maintained by an employer;

(C) a governmental or church plan defined in 26 USC 414, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under 26 USC 457;

(D) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(E) settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(F) formal prepaid funeral contracts.

(Adopted effective August 4, 2005; amended November 10, 2008, February 18, 2012)

Sec. 38a-432a-4. Definitions

As used in sections 38a-432a-1 to 38a-432a-8, inclusive, of the Regulations of Connecticut State Agencies.

(1) "Agency" means a person that employs one or more insurance producers;

(2) "Annuity" means "annuities" as defined in section 38a-1 of the Connecticut General Statutes, that is or are individually solicited, whether the product is classified as an individual or group annuity;

- (3) “Commissioner” means the Insurance Commissioner.
- (4) “Continuing education credit” or “CE credit” means a “credit hour” as defined in section 38a-782a-1 of the Regulations of Connecticut State Agencies;
- (5) “Continuing education provider” or “CE provider” means a person that is approved to sponsor continuing education courses pursuant to section 38a-782a-4 of the Regulations of Connecticut State Agencies;
- (6) “FINRA” means the federal Financial Industry Regulatory Authority or a succeeding agency;
- (7) “Insurance producer” means “Insurance producer” as defined in section 38a-702a of the Connecticut General Statutes;
- (8) “Insurer” means “insurer” as defined in section 38a-1 of the Connecticut General Statutes;
- (9) “Person” means “person” as defined in section 38a-702a of the Connecticut General Statutes;
- (10) “Recommendation” means advice provided by an insurance producer or an insurer where no producer is involved, to an individual consumer that results in a purchase, exchange or replacement of an annuity in accordance with that advice;
- (11) “Replacement” means a transaction in which a new annuity policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that by reason of the transaction, an existing annuity policy or contract has been or is to be:
 - (A) Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer 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) Used in a financed purchase; and
- (12) “Suitability information” means information that is reasonably appropriate in determining the suitability of a recommendation, including the following:
 - (A) Age;
 - (B) Annual income;
 - (C) Financial situation and needs, including the financial resources used for the funding of the annuity;
 - (D) Financial experience;
 - (E) Financial objectives;
 - (F) Intended use of the annuity;
 - (G) Financial time horizon;
 - (H) Existing assets, including investment and life insurance holdings;
 - (I) Liquidity needs;
 - (J) Risk tolerance; and
 - (K) Tax status.

(Adopted effective August 4, 2005; amended November 10, 2008, February 18, 2012)

Sec. 38a-432a-5. Duties of insurers, agencies and insurance producers

(a) In recommending to a consumer the purchase, exchange or replacement of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no insurance producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for

the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis for the insurance producer or the insurer to believe all of the following:

(1) The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, replaces, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on investment returns, insurance and investment components and market risk;

(2) The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;

(3) The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and

(4) In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:

(A) The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;

(B) The consumer would benefit from product enhancements and improvements; and

(C) The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding thirty-six (36) months.

(b) Prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, shall make reasonable efforts to obtain the consumer's suitability information.

(c) Except as permitted under subsection (d) of this section, an insurer shall not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity is suitable based on the consumer's suitability information.

(d) (1) Except as provided under subdivision (2) of this subsection, neither an insurance producer nor an insurer shall have any obligation to a consumer under subsection (a) or (c) of this section related to any annuity transaction if:

(A) No recommendation is made;

(B) A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer;

(C) A consumer refuses to provide relevant suitability information and the annuity transaction is not recommended; or;

(D) A consumer decides to enter into an insurance transaction that is not based on a recommendation of the insurer or insurance producer.

(2) An insurer's issuance of an annuity subject to subdivision (1) of this subsection shall be reasonable under all the circumstances actually known to the insurer or insurance producer at the time the annuity is issued.

(e) An insurance producer or, where no insurance producer is involved, the responsible insurer representative, shall at the time of sale:

(1) Make a record of any recommendation described in subsection (a) of this section;

(2) Obtain a customer signed statement documenting a customer's refusal to provide suitability information, if applicable; and

(3) Obtain a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.

(f) (1) An insurer shall establish a system of supervision that is reasonably designed to achieve the insurer's and its insurance producers' compliance with sections 38a-432a-1 to 38a-432-8, inclusive, of the Regulations of Connecticut State Agencies, including, but not limited to the following:

(A) The insurer shall maintain reasonable procedures to inform its insurance producers of the requirements of sections 38a-432a-1 to 38a-432a-8, inclusive, of the Regulations of Connecticut State Agencies and shall incorporate the requirements of this regulation into relevant insurance producer training manuals;

(B) The insurer shall establish standards for insurance producer product training and shall maintain reasonable procedures to require its insurance producers to comply with the requirements of section 38a-432a-8 of the Regulations of Connecticut State Agencies;

(C) The insurer shall provide product-specific training and training materials which explain all material features of its annuity products to its insurance producers;

(D) The insurer shall maintain procedures for review of each recommendation prior to issuance of an annuity that are designed to ensure that there is a reasonable basis to determine that a recommendation is suitable. Such review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;

(E) The insurer shall maintain reasonable procedures to detect recommendations that are not suitable. This may include, but is not limited to, confirmation of consumer suitability information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this subparagraph by applying sampling procedures, or by confirming suitability information after issuance or delivery of the annuity; and

(F) The insurer shall annually provide a report to senior management, including to the senior manager responsible for audit functions, which details an analysis, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

(G) Nothing in this subsection restricts an insurer from contracting for performance of a function (including maintenance of procedures) required under this subdivision. An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to the Connecticut General Statutes regardless of whether the insurer contracts for performance of a function, and regardless of the insurer's compliance with subparagraph (H) of this subdivision.

(H) An insurer's system of supervision under this subdivision shall include supervision of the contractual performance under this subsection. This includes, but is not limited to, the following:

(i) Monitoring and, as appropriate, conducting audits to ensure that the contracted function is properly performed; and

(ii) Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

(2) An insurer is not required to include in its system of supervision an insurance producer's recommendations to consumers of products other than the annuities offered by the insurer.

(g) An insurance producer shall not dissuade, or attempt to dissuade, a consumer from:

(1) Truthfully responding to an insurer's request for confirmation of suitability information;

(2) Filing a complaint; or

(3) Cooperating with the investigation of a complaint.

(h)(1) Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions and the provisions of subdivision (2) of this subsection shall satisfy the requirements under sections 38a-432a-1 to 38a-432a-8, inclusive, of the Regulations of Connecticut State Agencies. This subsection applies to FINRA broker-dealer sales of variable annuities and fixed annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the commissioner's ability to enforce the provisions of sections 38a-432a-1 to 38a-432a-8, inclusive, of the Regulations of Connecticut State Agencies, including the conducting of investigations.

(2) For subdivision (1) of this subsection to apply, an insurer shall:

(A) Monitor the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and

(B) Provide to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

(Adopted effective August 4, 2005; amended November 10, 2008, February 18, 2012)

Sec. 38a-432a-6. Mitigation of responsibility

(a) An insurer is responsible for compliance with sections 38a-432a-1 to 38a-432a-8, inclusive, of the Regulations of Connecticut State Agencies. If a violation occurs, either because of the action or inaction of the insurer or its insurance producer, the commissioner may order:

(1) An insurer to take reasonably appropriate corrective action for any consumer harmed by the insurer's, or by its insurance producer's, violation of sections 38a-432a-1 to 38a-432a-8, inclusive, of the Regulations of Connecticut State Agencies; and

(2) a general agency, independent agency or an insurance producer to take reasonably appropriate corrective action for any consumer harmed by the insurance producer's violation of sections 38a-432a-1 to 38a-432a-8, inclusive, of the Regulations of Connecticut State Agencies.

(b) Any applicable penalty of the Connecticut General Statutes for a violation of sections 38a-432a-1 to 38a-432a-8, inclusive, of the Regulations of Connecticut State Agencies may be reduced or eliminated at the discretion of the commissioner, if corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice. Nothing contained in this section shall be construed to limit the commissioner's authority to terminate

or suspend a producer or insurer's license or to pursue other legal or regulatory action pursuant to the insurance laws of the state of Connecticut.

(Adopted effective August 4, 2005; amended November 10, 2008, February 18, 2012)

Sec. 38a-432a-7. Record keeping

(a) Insurers, agencies and insurance producers shall maintain or be able to make available to the commissioner records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions for seven years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

(b) Records required to be maintained by sections 38a-432a-1 to 38a-432a-8, inclusive, of the Regulations of Connecticut State Agencies may be maintained in paper, photographic, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

(Adopted effective August 4, 2005; amended November 10, 2008, February 18, 2012)

Sec. 38a-432a-8. Insurance producer training

(a) An insurance producer shall not solicit the sale of an annuity product unless the insurance producer has adequate knowledge of the product to recommend the annuity and the insurance producer is in compliance with the insurer's standards for product training. An insurance producer may rely on insurer-provided product-specific training standards and materials to comply with this subsection.

(b) (1) (A) An insurance producer who engages in the sale of annuity products shall complete a one-time four (4) CE credit training course approved by the commissioner and provided by the continuing education provider.

(B) Insurance producers who hold a life insurance line of authority on the effective date of this regulation and who desire to sell annuities shall complete the requirements of this subsection within six (6) months after the effective date of this regulation. Individuals who obtain a life insurance line of authority on or after the effective date of this regulation may not engage in the sale of annuities until the annuity training course required under this subsection has been completed.

(2) The minimum length of the training required under this subsection shall be sufficient to qualify for at least four (4) CE credits, but may be longer.

(3) The training required under this subsection shall include information on the following topics:

- (A) The types of annuities and various classifications of annuities;
- (B) Identification of the parties to an annuity;
- (C) How fixed, variable and indexed annuity contract provisions affect consumers;
- (D) The application of income taxation of qualified and non-qualified annuities;
- (E) The primary uses of annuities; and
- (F) Appropriate sales practices, replacement and disclosure requirements.

(4) Providers of courses intended to comply with this subsection shall cover all topics listed in subdivision (3) of this subsection and shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required topics.

(5) A provider of an annuity training course intended to comply with this subsection shall register as a CE provider in this state and comply with the rules and guidelines applicable to insurance producer continuing education courses as set forth

in sections 38a-782a-1 to section 38a-782a-17, inclusive, of the Regulations of Connecticut State Agencies.

(6) Annuity training courses may be conducted and completed by classroom method or by self-study method in accordance with section 38a-782a-7 of the Regulations of Connecticut State Agencies.

(7) Providers of annuity training shall comply with the reporting requirements and shall issue certificates of completion in accordance with section 38a-782a-4 of the Regulations of Connecticut State Agencies.

(8) The satisfaction of the training requirements of another state that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection in this state.

(9) An insurer shall verify that an insurance producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by commissioner-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

(Adopted effective February 18, 2012)

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Use of Senior-Specific Certifications and Professional Designations in the Sale of Life Insurance and Annuities

Sec. 38a-432b-1. Definitions and scope

(a) For purposes of this regulation, “insurance producer” means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities.

(b) This regulation shall apply to any solicitation, sale or purchase of, or advice made in connection with, a life insurance or annuity product by an insurance producer.

(Adopted effective July 7, 2010)

Sec. 38a-432b-2. Prohibited uses of senior-specific certifications and professional designations

(a) It is a prohibited practice in the business of insurance, and constitutes cause for the suspension or revocation of insurance licenses or for the imposition of fines pursuant to section 38a-774 of the Connecticut General Statutes, for an insurance producer to use a senior-specific certification or professional designation in such a way as to mislead a purchaser or prospective purchaser that the insurance producer has special certification or training in advising or servicing seniors (1) in connection with the solicitation, sale or purchase of a life insurance or annuity product, (2) in the provision of advice as to the value of or the advisability of purchasing or selling a life insurance or annuity product, either directly or indirectly through publications or writings, (3) in the issuance or promulgation of analyses or reports related to a life insurance or annuity product.

(b) The following uses of senior-specific certifications or professional designations shall be prohibited:

(1) Use of a certification or professional designation by an insurance producer who has not actually earned or is otherwise ineligible to use such certification or designation;

(2) Use of a nonexistent or self-conferred certification or professional designation;

(3) Use of a certification or professional designation that indicates or implies a level of occupational qualifications obtained through education, training or experience that the insurance producer using the certification or designation does not have; and

(4) Use of a certification or professional designation that was obtained from a certifying or designating organization that: (i) Is primarily engaged in the business of instruction in sales or marketing; (ii) does not have reasonable standards or procedures for assuring the competency of its certificants or designees; (iii) does not have reasonable standards or procedures for monitoring and disciplining its certificants or designees for improper or unethical conduct; or (iv) does not have reasonable continuing education requirements for its certificants or designees in order to maintain the certificate or designation.

(Adopted effective July 7, 2010)

Sec. 38a-432b-3. Qualified certifying or designating organizations

An insurance producer may use a certification or professional designation issued by a certifying or designating organization where (1) such certification or designation does not primarily apply to sales or marketing, and (2) the certifying or designating organization has been accredited by (i) The American National Standards Institute (ANSI), (ii) the National Commission for Certifying Agencies, or (iii) any organiza-

tion that is on the U.S. Department of Education's list entitled "Accrediting Agencies Recognized for Title IV Purposes."

(Adopted effective July 7, 2010)

Sec. 38a-432b-4. Determining factors

(a) In determining whether a combination of words or an acronym standing for a combination of words constitutes a certification or professional designation indicating or implying that a person has special certification or training in advising or servicing seniors, factors to be considered shall include: (1) Use of one or more words such as "senior," "retirement," "elder," or like words combined with one or more words such as "certified," "registered," "chartered," "advisor," "specialist," "consultant," "planner," or like words, in the name of the certification or professional designation; and (2) the manner in which those words are combined.

(b) For purposes of this regulation, a job title within an organization that is licensed or registered by a state or federal financial services regulatory agency is not a certification or professional designation, unless it is used in a manner that would confuse or mislead a reasonable consumer, when the job title: (1) Indicates seniority or standing within the organization; or (b) specifies an individual's area of specialization within the organization.

(c) For purposes of subsection (b) of this section, financial services regulatory agency includes, but is not limited to, an agency that regulates insurers, insurance producers, broker-dealers, investment advisers, or investment companies as defined under the Investment Company Act of 1940.

(Adopted effective July 7, 2010)

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Variable Life Insurance

Sec. 38a-433-1. Authority

Sections 38a-433-2 to 38a-433-11, inclusive, applicable to variable life insurance policies, Sections 38a-433-12 to 38a-433-22, inclusive, applicable to Modified Guaranteed Annuities and Sections 38a-433-23 to 38a-433-32, inclusive, applicable to modified guaranteed life insurance, are promulgated under the authority of Section 38a-433 (e) of the Connecticut General Statutes.

(Effective September 25, 1992)

Sec. 38a-433-2. Definitions

As used in this regulation: (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 (10) percent 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 making 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 defined in this section.

(h) “General account” means all assets of the insurer other than assets in separate accounts established pursuant to Title 38a of the Connecticut General Statutes 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 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 Section 38a-433 of the Connecticut General Statutes 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 Section 38a-433 of the Connecticut General Statutes or pursuant to the corresponding section of the Insurance Laws of the state of domicile of a foreign or alien insurer.

(Effective September 25, 1992)

Sec. 38a-433-3. Qualification of insurer to issue variable life insurance

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.

(a) **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:

(1) the insurer is licensed or organized to do a life insurance business in this state;

(2) the insurer has obtained a license from the Commissioner for the issuance of variable life insurance policies in this state. The Commissioner shall grant such license only after he has found that:

(A) the plan of operation for the issuance of variable life insurance policies is not unsound;

(B) 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; and

(C) the present and foreseeable 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:

- (i) the history of operation and financial condition of the insurer;
- (ii) 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;
- (iii) 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; and
- (iv) 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.

(b) **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 Section 38a-433-3 (a) (2):

- (1) copies of and a general description of the variable life insurance policies it intends to issue;
- (2) 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;
- (3) with respect to any separate account maintained by an insurer for any variable life insurance policy, a statement of the investment policy the insurer intends to follow for the investment of the assets held in such separate account. The statement shall include a description of the investment objective intended for the separate account;
- (4) a description of any investment advisory services contemplated as required by Subsection (j) of Sec. 38a-433-6;
- (5) 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; and
- (6) a statement of the insurer's actuary describing the mortality and expense risks which the insurer will bear under the policy.

(c) **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 recommendation 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.

(d) **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.

(1) All variable life insurance sales material, advertising material, and descriptive literature shall be filed 30 business days prior to use with the Commissioner who shall require an insurer to cease the use of any such materials upon finding that any such materials are false, misleading, deceptive, or inaccurate. Revised versions of such materials containing changes of substantial import from versions on file with the Commissioner shall be filed with the Commissioner.

(2) For purposes of this regulation, variable insurance sales material, advertising material, or descriptive literature shall include but is not limited to:

(A) printed and published material, audio-visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV and film scripts, billboards, and similar displays for variable life insurance;

(B) descriptive literature and sales aids of all kinds used to sell variable life insurance by or on behalf of an insurer or any person authorized to sell variable life insurance for presentation to members of the insurance-buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and

(C) prepared sales talks, presentations, and material for use in the sale of variable life insurance by any person authorized to sell variable life insurance.

(e) **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 these regulations and any other applicable law or regulations.

(f) **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 this regulation or any other applicable laws or regulations:

(1) An Annual Statement of the business of its separate account or accounts in such form as may be prescribed by the Commissioner; and

(2) prior to the use in this state any Information Furnished to applicants as provided for in Sec. 38a-433-7; and

(3) prior to the use in this state the form of any of the Reports to Policyholders as provided for in Sec. 38a-433-9; and

(4) 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.

(g) **Authority of commissioner to disapprove:** Any material required to be filed with and approved by the Commissioner shall be subject to disapproval if at any time it is found by him not to comply with the standards established by this regulation.

(Effective September 25, 1992)

Sec. 38a-433-4. Insurance policy requirements

Policy Qualification: The Commissioner shall not approve any variable life insurance form filed pursuant to this regulation unless it conforms to the requirements of this Section.

(a) **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 of such filing and approval shall be, to the extent appropriate and not inconsistent with this regulation, 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 this regulation.

(b) **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 risk 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.

(3) The policy shall reflect the investment experience of one or more separate accounts established and maintained by the insurer. The insurer must demonstrate that the reflection of investment experience in 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 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 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.

(c) **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 page 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 benefit 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 section 38a-433-4 (b) (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 10 days of receipt of the policy by the policyholder, and receive a refund equal to the sum of (a) 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 (b) 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; and

(F) such other items as are currently required for fixed benefit life insurance policies and which are not inconsistent with this regulation.

(2) For scheduled premium policies, a provision for a grace period of not less than thirty-one 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.

(3) 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 61 days after the mailing date of the report of policyholders required by section 38a-433-9 (c).

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 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.

(4) For scheduled premium policies, a provision that the policy will be reinstated at any time within two 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 and any other indebtedness in effect at the end of the grace period following the date of default with interest at the rate permitted by section 38a-444 of the General Statutes; or

(B) 110% of the increase in cash value resulting from reinstatement.

(5) 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;

(6) 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; and

(B) the assets of such separate account shall be valued at least as often as any policy benefits vary but at least monthly.

(7) A provision that at any time during the first eighteen months of the variable life insurance policy, the owner may exchange the policy for a policy of permanent fixed benefit insurance for the same initial amount of insurance as the variable life insurance policy, provided that the new policy:

(A) shall bear the same date of issue and age at issue as the original variable life insurance policy;

(B) is issued on any plan of permanent insurance offered by the insurer or an affiliate on the date of issue of the variable life insurance policy and premium rates in effect on that date for the same class of insurance;

(C) Includes such riders and incidental insurance benefits as were included in the original policy if such riders and incidental insurance benefits are issued with the fixed benefit policy. If the conversion results in an increase or decrease in cash value, such increase or decrease will be payable to the insurer or the insured as the case may be.

(D) Must apply as an advance premium on the new policy any excess of the accrued premium on the original variable life insurance policy from the date of issue to the date of request for exchange over the corresponding accrued premium on the new fixed benefit policy, except that any portion of such excess which is less than a regular mode premium on the new policy may either be applied as an advance premium or refunded in cash at the option of the insurer.

(E) Shall not require evidence of insurability for this exchange.

(8) A provision specifying what documents constitute the entire insurance contract;

(9) A designation of the officers of the insurer 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;

(10) an identification of the owner of the insurance contract;

(11) 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;

(12) a statement of any conditions or requirements concerning the assignment of the policy;

(13) A description of any adjustments in policy values to be made in the event of misstatement of age or sex of the insured;

(14) A provision that the policy shall be incontestable by the insurer after it has been in force for two 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 years from the date of issue of such increase;

(15) 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;

(16) 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 months from the date of request; or

(B) 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.

(17) If settlement options are provided, at least one such option shall be provided on a fixed basis only;

(18) A description of the basis for computing the cash value and the surrender value under the policy shall be included.

(19) Premiums or charges for incidental insurance benefits shall be stated separately;

(20) Any other policy provisions required by this regulation;

(21) Such other items as are currently required for fixed benefit life insurance policies and are not inconsistent with this regulation.

(22) 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.

(d) **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:

(1) A provision for policy loans which provides the following:

(A) At least 75% of the policy's cash surrender value may be borrowed;

(B) The amount borrowed shall bear interest at a rate not to exceed that permitted by Section 38a-444 of the General Statutes.

(C) Any indebtedness shall be deducted from the proceeds payable on death.

(D) Any indebtedness shall be deducted from the cash surrender value upon surrender or in determining any non-forfeiture benefit.

(E) 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 days after the date of mailing of such notice. For flexible premium policies, whenever the total charges authorized by the policy that are necessary to keep the policy in force until the next following policy 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 Section 38a-433-9 (c).

(F) 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.

(G) 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.

(H) No policy loan provision is required if the policy is under the extended insurance non-forfeiture option.

(I) The policy loan provisions shall be constructed so that variable life insurance policyholders who have not exercised such provision are not disadvantaged by the exercise thereof.

(J) 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.

(e) **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 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 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 options:

(A) The amount of the dividend may be credited against premium payments;

(B) The amount of the dividend may be applied to provide paid-up 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 or partial withdrawals under this section, except that a restriction that no more than two 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.

(Effective September 25, 1992)

Sec. 38a-433-5. Reserve liabilities for variable life insurance

(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 full year from the valuation date, of the guarantee on each variable life insurance contract, assuming an immediate one-third 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 and shall equal the "residue," as described in paragraph (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 paragraph (B) below.

(A) The "residue" of the prior year's "attained age level" reserve on each variable life insurance contract shall not be less than zero 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 Subsection (b) of this Section 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 the 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 paragraph (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 rate permitted for the violation of life insurance 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 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 shall be maintained in a separate account, in amounts determined in accordance with the actuarial procedures appropriate to such benefit.

(Effective September 25, 1992)

Sec. 38a-433-6. Separate accounts

The following requirements apply to the establishment and administration of variable life insurance separate accounts by any domestic insurer:

(a) **Establishment and administration of separate accounts:** Any domestic insurer issuing variable life insurance shall establish one or more separate accounts pursuant to Section 38a-433 of the Connecticut General Statutes.

(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 assets any person who:

(A) Within the last ten 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, 1343 of Title 18, United States Code; or

(B) Within the last ten years has been found by any 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.

(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.

(b) **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.

(c) **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 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.

(d) **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 separate account in such security valued as required by sections 38a-433-1 to 38a-433-11, inclusive, of the Regulations of Connecticut State Agencies, would exceed 10% of the value of the assets of the separate account. The commissioner may waive this limitation in writing if the commissioner 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 10% of the total issued and outstanding voting securities of such issuer. The commissioner may waive this limitation in writing if the commissioner believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders of this state or jeopardize the independent operation of the issuer of such securities.

(3) The percentage limitation specified in subdivision (1) of this subsection shall not be construed to preclude the investment of the assets of separate accounts in shares of investment companies registered pursuant to the federal Investment Company Act of 1940 or other pools of investment assets if the investment policies of such investment companies or asset pools comply substantially with the provisions of subsection (c) of this section and other applicable portions of sections 38a-433-1 to 38a-433-11, inclusive, of the Regulations of Connecticut State Agencies.

(e) **Valuation of assets of a separate account.** (1) 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.

(f) **Separate account investment policy.** (1) The investment policy of a separate account operate account operated by a domestic insurer filed under Section 38a-433-3 (b) (3) shall not be changed without first filing such change with the Insurance Commissioner.

(2) With respect to changes of investment policy for which the Commissioner must give his approval, the following regulations shall apply:

(A) Any change filed pursuant to this section shall be effective sixty days after the date it was filed with the Commissioner, unless the Commissioner notifies the insurer before the end of such sixty-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 section.

(B) The Commissioner may disapprove the change only if he determines that the change would be detrimental to the interest of the policyholders participating in such separate account.

(g) **Charges against a separate account.** (1) 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:

(A) taxes or reserves for taxes attributable to investment gains and income of the separate account;

(B) actual cost of reasonable brokerage fees and similar direct acquisition and sales costs incurred in the purchase or sale of separate account assets;

(C) actuarially determined costs of insurance (tabular costs) and the release of reserves and benefit base consistent with the release of separate account liabilities;

(D) charges for administrative expenses and investment management expenses, including internal costs attributable to the investment management of assets of the separate account;

(E) A charge, at a rate specified in the policy, for mortality and expense guarantees;

(F) Any amounts in excess of those required to be held in the separate account;

(G) Charges for incidental insurance benefits.

(h) **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.

(i) **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.

(j) **Investment advisory services to a separate account.** (1) [a.] 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:

(A) the person providing such advice is registered as an investment adviser under the Investment Advisers Act of 1940; or

(B) the insurer has filed with the Commissioner and continues to file annually the following information and statements concerning the proposed adviser:

(i) the name and form of organization, state of organization, and its principal place of business;

(ii) 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;

(iii) a written Standard of Conduct complying in substance with the requirements of Section 8 of this Article which has been adopted by the investment adviser and is applicable to the investment adviser, its officers, directors, and affiliates;

(iv) a statement provided by the proposed adviser as to whether the adviser or any person associated therewith:

(aa) has been convicted within ten years of any felony or misdemeanor arising out of such person's conduct as an employee, salesman, officer or director of an insurance company, a bank, 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;

(bb) 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.

(cc) has been found by federal or state regulatory authorities to have willfully violated or has acknowledged willful violation of any provision of federal or state securities laws or state insurance laws or of any rule or regulations under any such laws; or

(dd) 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

(C) 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 days' written notice to the investment adviser.

(2) 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 (of) or the (insurance company's) insurer's policyholders.

(Effective September 25, 1992; amended August 30, 2004)

Sec. 38a-433-7. Information furnished to applicants

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 acknowledgement 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 by the delivery to the applicant of a prospectus included in a registration statement which satisfies the requirements of the Securities Act of 1933 and which was declared effective by the Securities and Exchange Commission to the extent that the prospectus contains the information required by this Section.

(a) 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 Sections 38a-433-4 (c) (1) (E) and 38a-433 (c) (8);

(b) a statement of the investment policy of the separate account, including:

(1) a description of the investment objective intended for the separate account and the principal types of investments intended to be made; and

(2) any restriction or limitations on the manner in which the operations of the separate account are intended to be conducted.

(c) A statement of the net investment return of the separate account for each of the last ten years or such lesser period as the separate account has been in existence;

(d) a statement of the charges levied against the separate account during the previous year;

(e) a summary of the method to be used in valuing assets held by the separate account;

(f) a summary of the federal income tax aspects of the policy applicable to the insured, the policyholder and the beneficiary;

(g) 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 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.

(Effective September 25, 1992)

Sec. 38a-433-8. Applications

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.

(Effective September 25, 1992)

Sec. 38a-433-9. Reports to policyholders

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:

(a) Within thirty 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, and any optional payments allowed pursuant to Subsection (d) of Sec. 38a-433-4 under the policy computed as of the policy anniversary date. Provided, however, that such statement may be furnished within thirty 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 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 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. If the projected value is less than zero, a warning message must be included that states that the policy may be in danger of terminating without value in the next 12 months unless additional premium is paid.

(b) Annually, a statement or statements including:

(1) a summary of the financial statement of the separate account based on the annual statement last filed with the Commissioner;

(2) 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 years when available;

(3) 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;

(4) any charges levied against the separate account during the previous year;

(5) a statement of the portfolio turnover rate as defined herein during the preceding fiscal year of investments allocated to the separate account.

(A) The rate shall be calculated by dividing (A) the lesser of purchases of sales of portfolio securities for the particular fiscal year by (B) the monthly average of the value of the portfolio securities owned by the separate account during the

particular fiscal year. Such monthly average shall be calculated by totaling the values of the portfolio securities as of the beginning and end of the first month of the particular fiscal year and as of the end of each of the succeeding eleven months, and dividing the sum by 13, except that the average value of securities for which market quotations are not available may be based upon the value of such securities as of the end of the preceding fiscal quarters.

(B) For the purposes of this item, there shall be excluded from both the numerator and the denominator all U.S. Government securities (short-term and long-term) and all other securities whose maturities at the time of acquisition were one year or less. Purchases shall include any cash paid upon the conversion of one portfolio security into another. Purchases shall also include the cost of rights or warrants purchased. Sales shall include the net proceeds of the sale of rights or warrants. Sales shall also include the net proceeds of redemptions of portfolio securities by call or maturity.

(C) The insurer shall show, in addition to the calculated portfolio turnover rate, both the amount of the purchases and the amount of the sales (calculated as prescribed in (2) above) and the monthly average (but not the individual monthly figures) of the value of the portfolio securities owned by the separate account during the fiscal year.

(D) The insurer may, if it wishes, make any statement or explanation with respect to any significant variations in the portfolio turnover rate during the three fiscal years next preceding.

(6) 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; and

(7) the name of each broker or dealer handling portfolio transactions on behalf of the separate account in which the insurer or an affiliate has any material direct or indirect interest and the nature of such transactions and the amount of compensation received by each such broker or dealer from business originating with the separate account during the preceding fiscal year;

(c) 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.

(Effective September 25, 1992)

Sec. 38a-433-10. Qualification of agents for the sale of variable life insurance

(a) **Qualification to sell variable life insurance.** (1) No person may sell or offer for sale in this state any variable life insurance policy unless such person is an agent and has filed with the Commissioner, in a form satisfactory to the Commissioner, evidence that such person holds any license or authorization which may be required for the solicitation or sale of variable life insurance.

(2) Any examination administered by the Department for the purpose of determining the eligibility of any person for licensing as an agent shall, after the effective date of this regulation, include such questions concerning the history, purpose, regulation, and the sale of variable life insurance as the Commissioner deems appropriate.

(b) **Reports of disciplinary actions.** Any person qualified in this state under this Section to sell or offer to sell variable life insurance shall immediately report to the Commissioner:

(1) any suspension or revocation of his agent's license in any other state or territory of the United States;

(2) the imposition of any disciplinary sanction, including suspension or expulsion from membership, suspension or revocation of or denial of registration, imposed upon him by any national securities exchange, or national securities association, or any federal, state, or territorial agency with jurisdiction over securities or variable life insurance;

(3) any judgment or injunction entered against him on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or violation of any insurance or securities law or regulation.

(c) **Refusal to qualify agent to sell variable life insurance, suspension, revocation, or nonrenewal of qualification.** The Commissioner may reject any application or suspend or revoke or refuse to renew any agent's qualifications under this Article to sell or offer to sell variable life insurance upon any ground that would bar such applicant or such agent from being licensed to sell other life insurance contracts in this state. The rules governing any proceeding relating to the suspension or revocation of an agent's license shall also govern any proceeding or suspension or revocation of an agent's qualification to sell or offer to sell variable life insurance.

(Effective September 25, 1992)

Sec. 38a-433-11. Separability

If any provision of this regulation 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.

(Effective September 25, 1992)

Modified Guaranteed Annuities

Sec. 38a-433-12. Applicability and scope

This regulation shall apply to:

(1) The qualifications of agents to be authorized to sell Modified Guaranteed Annuity contracts in this state;

(2) the qualification of insurers to be authorized to issue such contracts;

(3) the required contract form and provisions for issue of such coverage in this state; and

(4) the manner in which separate account assets, supporting such issued contracts, are to be maintained and reported.

(Effective September 25, 1992)

Sec. 38a-433-13. Definitions

As used in Sections 38a-433-12a to 38a-433-21, inclusive:

(a) "Modified Guaranteed Annuity" means a deferred annuity contract, the underlying assets of which are held in a separate account, and the values of which are guaranteed if held for specified periods. It contains nonforfeiture values that are based upon a market-value adjustment formula if held for shorter periods. This formula may, or may not, reflect the value of assets held in the separate account.

The assets underlying the contract must be in a separate account during the period or periods, when the contract holder can surrender the contract.

(b) "Interest credits" means all interest that is credited to the contract.

(c) "Separate account" means a separate account established pursuant to Section 38a-433 of the Connecticut General Statutes or pursuant to the corresponding Section of the Insurance Laws of the state of domicile of a foreign or alien insurer.

(d) "Commissioner" means the Insurance Commissioner of this state.

(e) "Consumer Price Index" means the index for all urban consumers for all items as published by the Bureau of Labor Statistics of the United States Department of Labor or any successor agency.

(Effective September 25, 1992)

Sec. 38a-433-14. Authority of insurers

The following requirements are applicable to all insurers either seeking authority to issue Modified Guaranteed Annuities in this state or having authority to issue Modified Guaranteed Annuities in this state.

(a) **Licensing and Approval to do Business.** (1) No company shall deliver or issue for delivery Modified Guaranteed Annuities within this state unless it is licensed or organized to do a life insurance or annuity business in this state, and the Commissioner is satisfied that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. In this connection, the Commissioner shall consider among other things the history and financial condition of the company; the character, responsibility and fitness of the officers and directors of the company; and the law and regulation under which the company is authorized in the state of domicile to issue such annuities.

(2) If the company is a subsidiary of an admitted life insurance company, or affiliated with such company by common management or ownership, it may be deemed by the Commissioner to have satisfied the provision of subdivision (1) of this subsection if either it or such admitted life company satisfies the aforementioned provisions; provided, further, that companies licensed and having a satisfactory record of doing business in this state for a period of at least three years may be deemed to have satisfied the Commissioner with respect to subdivision (1) of this subsection.

(3) Before any company shall deliver or issue for delivery such annuities within this state it shall submit to the Commissioner a general description of the kinds of such annuities it intends to issue; if requested by the Commissioner, a copy of the statutes and regulations of its state of domicile under which it is authorized to issue such annuities; and if requested by the Commissioner, biographical data with respect to officers and directors of the company on the National Association of Insurance Commissioners uniform biographical data forms.

(b) **Use of Sales Materials.** An insurer authorized to transact Modified Guaranteed Annuity 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 Modified Guaranteed Annuity business in this state which is false, misleading, deceptive, or inaccurate.

Illustrations of benefits payable under any Modified Guaranteed Annuity shall not include projections of past investment experience into the future or attempted predictions of future investment experience; provided, that hypothetical assumed interest credits may be used to illustrate possible levels of benefits.

Before any insurer shall deliver or issue for delivery any Modified Guaranteed Annuity contract in this state, the Commissioner may require the filing of a copy of any prospectus or other sales material to be used in connection with the marketing of that insurer's Modified Guaranteed Annuity contract. The sales material must clearly illustrate that there can be both upward and downward adjustments due to the application of the market value adjustment formula in determining nonforfeiture benefits.

(c) **Reports.** Any insurer authorized to transact the business of Modified Guaranteed Annuities in this state shall submit to the Commissioner:

(1) a separate account annual statement which shall include the business of its Modified Guaranteed Annuities; and

(2) such additional information concerning its Modified Guaranteed Annuity operations or separate accounts as the Commissioner shall deem necessary.

(d) **Authority of Commissioner to Disapprove.** Any material required to be filed with and approved by the Commissioner shall be subject to disapproval if at any time it is found by the Commissioner not to comply with the standards established by this regulation.

(Effective September 25, 1992)

Sec. 38a-433-15. Filing of contracts

No Modified Guaranteed Annuity shall be delivered or issued for delivery to any person in this state, nor shall any application, rider or endorsement be used in connection therewith, until a copy of the forms thereof shall have been filed with and approved by the Commissioner. Filings shall include a demonstration in a form satisfactory to the Commissioner that the nonforfeiture provisions of the contract(s) comply with subsection 38a-433-16 (b).

(Effective September 25, 1992)

Sec. 38a-433-16. Modified guaranteed annuity contract requirements

(a) Mandatory Contract Benefit and Design Requirements.

(1) Any Modified Guaranteed Annuity contract delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of nonforfeiture benefits.

(2) No Modified Guaranteed Annuity contract calling for the payment of periodic stipulated payments shall be delivered or issued for delivery in this state unless it contains in substance the following provisions:

(A) A provision that there shall be a period of grace of thirty days or of one month, within which any stipulated payment to the insurer falling due after the first may be made, during which period of grace the contract shall continue in force. The contract may include a statement of the basis for determining the date as of which any such payment received during the period of grace shall be applied to produce the values under the contract arising therefrom;

(B) A provision that, at any time within one year from the date of default, in making periodic stipulated payments to the insurer during the life of the annuitant and unless the cash surrender value has been paid, the contract may be reinstated upon payment to the insurer of such overdue payments as required by contract, and of all indebtedness to the insurer on the contract, including interest. The contract may include a statement of the basis for determining the date as of which the amount to cover such overdue payments and indebtedness shall be applied to produce the values under the contract arising therefrom.

(3) The market-value adjustment formula, used in determining nonforfeiture benefits, must (A) be stated in the contract, (B) be applicable for both upward and downward adjustments, and (C) provide reasonable equity to both the contract holder and the insurance company. When a contract is filed with the Commissioner for approval, it must be accompanied by an actuarial statement indicating the basis for the market-value adjustment formula and that the formula provides reasonable equity to both the contract holder and the insurance company.

(4) If and to the extent so provided under the applicable contracts, that portion of the assets of any separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the company may conduct.

(b) **Nonforfeiture Benefits.**

(1) This subsection 38a-433-16 (b) shall not apply to any:

(A) immediate annuity,

(B) group annuity contract purchased in connection with one or more retirement plans or plans of deferred compensation established or maintained by or for one or more employers (including partnerships or sole proprietorships), employee organizations, or any combination thereof, other than plans providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended, or to any

(C) deferred annuity contract after annuity payments have commenced.

(2) No Modified Guaranteed Annuity contract shall be delivered or issued for delivery in this state unless it contains in substance the following provisions:

(A) That upon cessation of payment of considerations under a contract, the insurer will grant a paid-up annuity benefit on a plan described in the contract that complies with Section 38a-433-16 (b) (5) below. Such description will include a statement of the mortality table, if any, and guaranteed or assumed interest rates used in calculating annuity payments.

(B) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the insurer will pay in lieu of any paid-up annuity benefit a cash surrender benefit as described in the contract that complies with Section 38a-433-16 (b) (6) below. The contract may provide that the insurer may defer payment of such cash surrender benefit for a period of six months after demand.

(3) The minimum values as specified in this Section of any paid-up annuity, cash surrender or death benefits available under a Modified Guaranteed Annuity contract shall be based upon nonforfeiture amounts meeting the requirements of this subdivision, Section 38a-433-16 (b) (3).

The "Unadjusted Minimum Nonforfeiture Amount" on any date prior to the annuity commencement date shall be an amount equal to the percentages of net considerations (as specified in Section 38a-433-16 (b) (4) below) increased by the interest credits defined in Section 38a-433-13 (b) allocated to the percentage of net considerations, which amount shall be reduced to reflect the effect of:

(A) any partial withdrawals from or partial surrender of the contract;

(B) the amount of any indebtedness on the contract, including interest due and accrued;

(C) an annual contract charge not less than zero and equal to (i) the lesser of thirty dollars (\$30.00) or two percent (2%) of the end of year contract value less (ii) the amount of any annual contract charge deducted from any gross considerations credited to the contract during such contract year; and

(D) a transaction charge of ten dollars (\$10.00) for each transfer to another investment division within the same contract.

Guaranteed interest credits in each year for any period of time for which interest credits are guaranteed shall be reasonably related to the average interest credits over that period of time.

The "Minimum Nonforfeiture Amount" shall be the Unadjusted Minimum Nonforfeiture Amount adjusted by the market-value adjustment formula contained in the contract.

The annual contract charge of thirty dollars (\$30.00) and the transaction charge of ten dollars (\$10.00) referenced will be adjusted to reflect changes in the Consumer Price Index in accordance with Section 38a-433-16 (b) (4) below.

(4) The percentages of net considerations used to define the Minimum Nonforfeiture Amount in Section 38a-433-16 (b) (3) above shall meet the requirements of this subdivision, Section 38a-433-16 (b) (4).

(A) With respect to contracts providing for periodic considerations, the net considerations for a given contract year used to define the Minimum Nonforfeiture Amount shall be an amount not less than zero and shall be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of thirty dollars (\$30.00) and less a collection charge of one dollar and twenty-five cents (\$1.25) per consideration credited to the contract during that contract year and less any charges for premium taxes. The percentages of net considerations shall be sixty-five percent (65%) for the first contract year and eighty-seven and one-half percent (87¹/₂%) for the second and later contract years. Notwithstanding the provisions of the preceding sentence, the percentage shall be sixty-five percent (65%) of the portion of the total net consideration for any renewal contract year which exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was sixty-five percent (65%).

(B) With respect to contracts providing for a single consideration, the net consideration used to define the Minimum Nonforfeiture Amount shall be the gross consideration less a contract charge of seventy-five dollars (\$75.00) and less any charge for premium taxes. The percentage of the net consideration shall be ninety percent (90%).

The annual contract charge of thirty dollars (\$30.00), the collection charge of one dollar and twenty-five cents (\$1.25) per collection, and the single consideration contract charge of seventy-five dollars (\$75.00) referred to above, will be adjusted to reflect changes in the Consumer Price Index in accordance with Section 38a-433-16 (b) (4) (C) below.

(C) The above contract charges shall be multiplied by the ratio of (i) the Consumer Price Index for June of calendar year preceding the date of filing, to (ii) the Consumer Price Index for June, 1979.

(5) Any paid-up annuity benefit available under a Modified Guaranteed Annuity contract shall be such that its present value on the annuity commencement date is at least equal to the Minimum Nonforfeiture Amount on that date. Such present value shall be computed using the mortality table, if any, and the guaranteed or assumed interest rates used in calculating the annuity payments.

(6) For Modified Guaranteed Annuity contracts which provide cash surrender benefits, the cash surrender benefit at any time prior to the annuity commencement date shall not be less than the Minimum Nonforfeiture Amount next computed after the request for surrender is received by the insurer. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

(7) Any Modified Guaranteed Annuity contract which does not provide cash surrender benefits, or does not provide death benefits at least equal to the Minimum Nonforfeiture Amount, prior to the annuity commencement date shall include a statement in a prominent place in the contract that such benefits are not provided.

(8) Notwithstanding the requirements of this subsection, Section 38a-433-16 (b), a Modified Guaranteed Annuity contract may provide under the situations specified in (A) or (B) below, that the insurer, at its option, may cancel the annuity and pay the contract holder the larger of the Unadjusted Minimum Nonforfeiture Amount and the Minimum Nonforfeiture Amount, and by such payment be released of any further obligation under such contract:

(A) if at any time the annuity becomes payable, the larger of the Unadjusted Minimum Nonforfeiture Amount and the Minimum Nonforfeiture Amount is less than \$2,000, or would provide an income the initial amount of which is less than \$20 per month; or

(B) if prior to the time the annuity becomes payable under a periodic payment contract no considerations have been received under the contract for a period of two full years and both (i) the total considerations paid prior to such period, reduced to reflect any partial withdrawals from or partial surrenders of the contract, and (ii) the larger of the Unadjusted Minimum Nonforfeiture Amount and the Minimum Nonforfeiture Amount is less than \$2,000.

(9) For any Modified Guaranteed Annuity contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of Section 38a-433-16 (b) (2) above, additional benefits payable

(A) in the event of total and permanent disability,

(B) as reversionary annuity or deferred reversionary annuity benefits, or

(C) as other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this Section. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require Minimum Nonforfeiture Amounts, paid-up annuity, cash surrender and death benefits.

(c) **The Application.** The application for a Modified Guaranteed Annuity shall prominently set forth immediately preceding the signature line language denoting that amounts payable under the contract are subject to a market value adjustment prior to a date or dates specified in the contract.

(Effective September 25, 1992)

Sec. 38a-433-17. Reserve liabilities

Reserve liabilities for Modified Guaranteed Annuities shall be established in accordance with actuarial procedures that recognize: (a) that assets of the separate account are based on market values, (b) the variable nature of benefits provided, and (c) any mortality guarantees.

As a minimum, the separate account liability will equal the surrender value based upon the market-value adjustment formula contained in the contract. If that liability is greater than the market value of the assets, a transfer of assets will be made into

the separate account so that the market value of the assets at least equals that of the liabilities. Also, any additional reserve that is needed to cover future guaranteed benefits will also be set up by the valuation actuary.

The market-value adjustment formula, the interest guarantees, and the degree to which projected cash flow of assets and liabilities are matched must also be considered. Each year, the valuation actuary must provide an opinion on whether the assets in the separate account are adequate to provide all future benefits that are guaranteed.

(Effective September 25, 1992)

Sec. 38a-433-18. Separate accounts

The following requirements apply to the establishment and administration of Modified Guaranteed Annuity separate accounts by any domestic insurer:

(a) **Establishment and Administration of Separate Accounts.** Any domestic insurer issuing Modified Guaranteed Annuities shall establish one or more separate accounts pursuant to Section 38a-433 of the Connecticut General Statutes.

(b) **Amounts in the Separate Account.** The insurer shall maintain in each separate account assets with a market or other value comporting to standards set out in Section 38a-433 of the Connecticut General Statutes at least equal to the valuation reserves and other contract liabilities respecting such account.

(c) **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, or pursuant to standards contained in Section 38a-433 of the Connecticut General Statutes.

(d) **Investment Laws.** Unless otherwise approved by the Commissioner, separate accounts relating to Modified Guaranteed Annuities will be subject to investment laws applicable to the insurer's general asset account.

(Effective September 25, 1992)

Sec. 38a-433-19. Reports to policyholders

Companies will annually provide their contractholders with a report showing both the account value and the cash surrender value. The report should clearly indicate that the account value is prior to the application of any surrender charges or market value adjustment formula. It should also specify the surrender charge and market value adjustment used to determine the cash surrender value.

(Effective September 25, 1992)

Sec. 38a-433-20. Foreign companies

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 these regulations, the Commissioner to the extent deemed appropriate by him or her may consider compliance with such law or regulation as compliance with this rule.

(Effective September 25, 1992)

Sec. 38a-433-21. Authorization of agents

No person, corporation, partnership, or other legal entity may sell or offer for sale in this state any Modified Guaranteed Annuity contract unless licensed to sell variable annuities under the insurance laws of this state.

(Effective September 25, 1992)

Sec. 38a-433-22. Separability

If any provision of this regulation 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.

(Effective September 25, 1992)

Modified Guaranteed Life Insurance

Sec. 38a-433-23. Definitions

(a) "Modified Guaranteed Life Insurance Policy" means an individual policy of life insurance, the underlying assets of which are held in a separate account, and the values of which are guaranteed if held for specified periods. It contains nonforfeiture values that are based upon a market value adjustment formula if held for shorter periods. The formula may, or may not, reflect the value of assets held in the separate account. The assets underlying the policy must be in a separate account during the period, or periods, when the policyholder can surrender the policy.

(b) "Agent" means any person, corporation, partnership, or other legal entity which is licensed by this state as a life insurance agent.

(c) "Interest Credits" means all interest that is credited to the policy.

(d) "Commissioner" means the Insurance Commissioner of this state.

(e) "Person" means an individual, corporation, partnership, association, trust, or fund.

(f) "Separate account" means a separate account established pursuant to Section 38a-433 of the Connecticut General Statutes or pursuant to the corresponding Section of the Insurance Laws of the state of domicile of a foreign or alien insurer.

(g) "Policy processing day" means the day on which charges authorized in the policy are deducted from the policy's cash value.

(h) "Unadjusted cash value" is the cash value before application of the market value adjustment formula and any surrender charge contained in the policy.

(Effective September 25, 1992)

Sec. 38a-433-24. Authority of insurers

The following requirements are applicable to all insurers either seeking authority to issue Modified Guaranteed Life Insurance in this state or having authority to issue Modified Guaranteed Life Insurance in this state.

(a) Licensing and Approval to do Business.

(1) No company shall deliver or issue for delivery Modified Guaranteed Life Insurance within this state unless it is licensed to do a life insurance or annuity business in this state, and the Commissioner is satisfied that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. In this connection, the Commissioner shall consider among other things the history and financial condition of the company; the character, responsibility and fitness of the officers and directors of the company; and the law and regulation under which the company is authorized in the state of domicile to conduct such business.

(2) If the company is a subsidiary of an admitted life insurance company, or affiliated with such company by common management or ownership, it may be deemed by the Commissioner to have satisfied the provision of subdivision (1) of this subsection if either it or such admitted life company satisfies the aforementioned provisions; provided, further, that companies licensed and having a satisfactory record of doing business in this state for a period of at least three years may be deemed to have satisfied the Commissioner with respect to subdivision (1) of this subsection.

(3) Before any company shall deliver or issue for delivery such life insurance within this state it shall submit to the Commissioner a general description of the kinds of such life insurance it intends to issue; if requested by the Commissioner, a copy of the statutes and regulations of its state of domicile under which it is authorized to issue such life insurance; and if requested by the Commissioner, biographical data with respect to officers and directors of the company on the NAIC uniform biographical data forms.

(b) **Use of Sales Materials.** An insurer authorized to transact Modified Guaranteed 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 Modified Guaranteed Life Insurance business in this state which is false, misleading, deceptive or inaccurate.

Illustrations of benefits payable under any Modified Guaranteed Life Insurance shall not include projections of past investment experience into the future or attempted predictions of future investment experience; provided, that hypothetical assumed interest credits may be used to illustrate possible levels of benefits if it is made clear that such assumed rates are hypothetical only.

Before any insurer shall deliver or issue for delivery any Modified Guaranteed Life Insurance Policy in this state, the Commissioner may require the filing of a copy of any prospectus or other sales material to be used in connection with the marketing of that insurer's Modified Guaranteed Life Insurance Policy. The sales material must clearly illustrate that there can be both upward and downward adjustments due to the application of the market value adjustment formula in determining nonforfeiture benefits.

(c) **Reports to Commissioner.** Any insurer authorized to transact the business of Modified Guaranteed Life Insurance in this state shall submit to the Commissioner: (1) a separate account annual statement which shall include the business of its Modified Guaranteed Life Insurance; and (2) such additional information concerning its Modified Guaranteed Life Insurance operations or separate accounts as the Commissioner shall deem necessary.

(d) **Authority of Commissioner to Disapprove.** Any material required to be filed with and approved by the Commissioner shall be subject to disapproval if at any time it is found by the Commissioner not to comply with the standards established by this regulation.

(Effective September 25, 1992)

Sec. 38a-433-25. Filing requirements

The filing requirements applicable to Modified Guaranteed Life Insurance shall be those filing requirements otherwise applicable under existing statutes and regulations of this state with respect to individual life insurance policy form filings, to the extent appropriate; provided, however, filings shall include a demonstration in a form satisfactory to the Commissioner that the nonforfeiture provisions of the contract(s) comply with Section 38a-433-26.

(Effective September 25, 1992)

Sec. 38a-433-26. Policy requirements

(a) **Mandatory Policy Benefit and Design Requirements.** Modified Guaranteed 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 maximum 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 subdivision (b) (4) of this section).

(3) The cash value of each Modified Guaranteed Life Insurance Policy shall be determined at least monthly. The method of computation of cash values and other nonforfeiture benefits shall be described in the policy. The market value adjustment formula, used in determining nonforfeiture benefits, must be stated in the policy and must be applicable for both upward and downward adjustments. The insurer must submit an actuarial statement indicating the basis for the market value adjustment formula and that the formula provides reasonable equity to both the policyholder and the insurer.

(4) The insurer must demonstrate that, if the interest credits at all times from the date of issue equal those guaranteed in the policy, with premiums and benefits determined accordingly under the terms of the policy, then the resulting unadjusted cash values and other nonforfeiture benefits must be at least equal to the minimum values required by Section 38a-78 of the Connecticut General Statutes for a fixed benefit general account policy with such premiums and benefits.

Guaranteed interest credits in each year for any period of time for which interest credits are guaranteed shall be reasonably related to the average guaranteed interest credits over that period of time.

(5) At the end of any specified guarantee period, the policyowner may select a new guarantee period. At those times, the policyowner must have the option of selecting a guarantee period of not more than five years, or a guarantee period that runs to the end of the coverage period, if shorter.

(b) **Mandatory Policy Provisions.** Every Modified Guaranteed 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 page of each such policy shall contain:

(A) A prominent statement that cash values may increase or decrease in accordance with the market value adjustment formula.

(B) To the extent permitted by state law, a captioned provision that the policyholder may return the Modified Guaranteed Life Insurance Policy within 10 days of receipt of the policy by the policyholder, and receive a refund equal to the sum of (1) 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 (2) 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, as determined by the market value adjustment formula. 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.

(C) Such other items as are currently required for fixed benefit life insurance policies and which are not inconsistent with this regulation.

(2) If settlement options are provided, at least one such option shall be provided on a fixed basis only;

(3) A description of the basis for computing the cash value and the surrender value under the policy shall be included;

(4) Premiums or charges for incidental insurance benefits shall be stated separately;

(5) Any other policy provision required by this regulation;

(6) Such other items as are currently required for fixed benefit life insurance policies and are not inconsistent with this regulation;

(7) A provision for nonforfeiture insurance benefits. The insurer may establish a reasonable minimum cash value below which any such nonforfeiture insurance options will not be available.

(c) **Policy Loan Provisions.** Every Modified Guaranteed Life Insurance Policy, delivered or issued for delivery in this state shall contain provisions which are not less favorable to the policyholder than the following:

(1) A provision for policy loans after the policy has been in force in 3 full years which provides the following:

(A) At least 75% of the policy's cash surrender value may be borrowed;

(B) The amount borrowed shall bear interest at a rate not to exceed that permitted by state insurance law;

(C) Any indebtedness shall be deducted from the proceeds payable on death;

(D) Any indebtedness shall be deducted from the cash surrender value upon surrender or in determining any nonforfeiture benefit;

(E) 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 days after the date of mailing of such notice. For flexible premium policies, whenever the total charges authorized by the policy that are necessary to keep the policy in force until the next following policy 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 subsection (b) of Section 38a-433-31;

(F) 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;

(G) No policy loan provision is required if the policy is under extended insurance nonforfeiture option;

(H) The policy loan provision shall be constructed so that life insurance policyholders who have not exercised such provisions are not disadvantaged by the exercise thereof;

(I) 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.

(d) **Other Policy Provisions.** The following provisions may in substance be included in a Modified Guaranteed Life Insurance Policy or related form delivered or issued for delivery in this state:

(1) An exclusion for suicide within two 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 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 other dividend options;

(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 subdivision (c) of this section, except that

a restriction that no more than two 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.

(Effective September 25, 1992)

Sec. 38a-433-27. Reserve liabilities

Reserve liabilities for Modified Guaranteed Life Insurance Policies shall be established in accordance with actuarial procedures that recognize: (1) that assets of the separate account are based on market value; (2) the variable nature of the benefits provided; and (3) any mortality guarantees.

As a minimum, the separate account liability will equal the surrender value based upon the market value adjustment formula contained in the policy. If that liability is greater than the market value of the assets, a transfer of assets will be made into the separate account so that the market value of the assets at least equals that of the liabilities. Any additional reserve that is needed to cover future guaranteed benefits shall be established.

The market value adjustment formula, the interest guarantees, and the degree to which projected cash flow of assets and liabilities are matched must also be considered. Each year the statement of actuarial opinion accompanying the annual statement shall include an opinion on whether the assets in the separate account are adequate to provide all future guaranteed benefits.

Reserve liabilities for all fixed incidental insurance benefits and any guarantees associated with variable incidental insurance benefits shall be maintained in the general account.

(Effective September 25, 1992)

Sec. 38a-433-28. Separate accounts

The following requirements apply to the establishment and administration of Modified Guaranteed Life Insurance separate accounts by any domestic insurer:

(a) **Establishment and Administration of Separate Accounts.** Any domestic insurer issuing Modified Guaranteed Life Insurance shall establish one or more separate accounts pursuant to Section 38a-433 of the Connecticut General Statutes.

(b) **Amounts in the Separate Account.** The insurer shall maintain in each separate account assets with a market or other value comporting to standards set out in Section 38a-433 of the Connecticut General Statutes at least equal to the valuation reserves and other contract liabilities respecting such account.

(c) **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, or pursuant to standards contained in Section 38a-433 of the Connecticut General Statutes.

(d) **Investment Laws.** Unless otherwise approved by the Commissioner, assets held in separate accounts relating to Modified Guaranteed Life Insurance will be considered general account assets for purposes of the investment laws.

(Effective September 25, 1992)

Sec. 38a-433-29. Information furnished to applicants

An insurer delivering or issuing for delivery in this state any Modified Guaranteed Life Insurance Policy 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 which is part of an effective registration statement under the Securities Act of 1933; or (2) all information and reports required by the Employee Retirement Income Securities Act of 1974 if the policies are exempted from the registration requirements of the Securities Act of 1933.

(a) A summary explanation, in non-technical terms, of the principal features of the policy, including a description of the manner in which the nonforfeiture benefits will be affected by the market value adjustment formula and the factors which affect such variation. Such explanation must include notices of the provision required by subdivision (b) (1) (B) of section 38a-433-26;

(b) A summary of the federal income tax aspects of the policy applicable to the insured, the policyholder and the beneficiary;

(c) Illustrations of benefits payable under the Modified Guaranteed Life Insurance Policy. 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.

(Effective September 25, 1992)

Sec. 38a-433-30. Applications

The application for a Modified Guaranteed Life Insurance Policy shall contain: (1) immediately preceding the signature line, language denoting that amounts payable under the policy are subject to a market value adjustment prior to a date or dates specified in the policy; and (2) questions designed to elicit information which enables the insurer to determine the suitability of Modified Guaranteed Life Insurance for the applicant.

(Effective September 25, 1992)

Sec. 38a-433-31. Reports to policyholders

Any insurer delivering or issuing for delivery in this state any Modified Guaranteed Life Insurance Policies shall mail to each Modified Guaranteed Life Insurance Policyholder at his or her last known address the following reports:

(a) Within thirty days after each anniversary of the policy, a report showing the unadjusted cash value, the cash surrender value, death benefit, any partial withdrawal or policy loan, any interest charge, and any optional payments allowed under the policy computed as of the policy anniversary date. The report should clearly indicate that the unadjusted cash value is prior to the application of any surrender charges or market value adjustment formula. It should also specify the surrender charge and market value adjustment used to determine the cash surrender value. Provided, however, that such report may be furnished within thirty 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 days prior to the mailing of such notice. This statement shall state that, in accordance with the market value adjustment formula, the cash values 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. For flexible premium policies, the report must contain a reconciliation of the change since the previous report in unadjusted 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 unadjusted cash value and cash surrender value, if different, as of one year from the end of the period covered by the report assuming that: (1) planned periodic premiums, if any, are paid as scheduled; (2) guaranteed costs of insurance are deducted; and (3) interest is credited at the guaranteed rate or, in the absence of a guaranteed rate, at a rate not greater than zero. If the projected value is less than zero, a warning message must be included that states that the policy may be in danger of terminating without value in the next 12 months unless additional premium is paid.

(b) 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.

(Effective September 25, 1992)

Sec. 38a-433-32. Foreign companies

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 these regulations, the Commissioner to the extent deemed appropriate by him in his discretion, may consider compliance with such law or regulation as compliance with these regulations.

(Effective September 25, 1992)

Sec. 38a-433-33. Authorization of agents

No person, corporation, partnership, or other legal entity may sell or offer for sale in this state any Modified Guaranteed Life Insurance Policy unless licensed to sell variable life insurance or variable annuity in this state.

(Effective September 25, 1992)

Sec. 38a-433-34. Separability

If any provision of this regulation 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.

(Effective September 25, 1992)

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Accident and Health Insurance Contracts**Sec. 38a-434-1. Guide for filing and approval**

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(Effective September 25, 1992)

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Mortality Tables: Minimum Nonforfeiture Benefits

NAIC Model Regulation Permitting Smoker/Nonsmoker Mortality Tables for Use in Determining Minimum Nonforfeiture Benefits

Sec. 38a-439-1. Purpose

The purpose of Sections 38a-439-2 to 38a-439-4, inclusive, is to permit the use of mortality tables that reflect differences in mortality between smokers and nonsmokers in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits for plans of insurance with separate premium rates for smokers and nonsmokers.

(Effective September 25, 1992)

Sec. 38a-439-2. Definitions

As used in Sections 38a-439-3 and 38a-439-4:

(a) “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) “1980 CET Table” means that mortality table consisting of separate rates of mortality for males and females 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) “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 Ordinary Mortality Table.

(d) “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) 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 recommended by the NAIC Technical Staff Actuarial Group.

(f) 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.

(Effective September 25, 1992)

Sec. 38a-439-3. Alternate tables

(a) For any policy of insurance delivered or issued for delivery in this state on or after the date of election pursuant to Section 38a-439 (e) (11) of the General Statutes for that policy form, but prior to January 1, 1989, a company may, subject

to the conditions of Section 38a-439-4, substitute for use in determining minimum cash surrender values and amounts of paid up nonforfeiture benefits: (1) the 1958 CSO Smoker and Nonsmoker Mortality Tables for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors; and (2) the 1958 CET Smoker and Nonsmoker Mortality Tables for the 1980 CET Table. Provided that for any category of insurance issued on female lives with 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 and before a date not later than January 1, 1989.

(b) For any policy of insurance delivered or issued for delivery in this state on or after the date of election pursuant to Section 38a-439 (e) (11) of the General Statutes for that policy form, a company may, subject to the conditions stated in Section 38a-439-4, substitute for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits: (1) the 1980 CSO Smoker and Nonsmoker Mortality Tables, with or without Ten-Year Select Mortality Factors, for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors; and (2) the 1980 CET Smoker and Nonsmoker Mortality Tables for the 1980 CET Table.

(Effective September 25, 1992)

Sec. 38a-439-4. Conditions

For each plan of insurance with separate rates for smokers and nonsmokers, an insurer may: (a) use composite mortality tables to determine minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or (b) use smoker and nonsmoker mortality to determine minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

(Effective September 25, 1992)

NAIC Procedure for Permitting Same Minimum Nonforfeiture Standards for Men and Women Under 1980 CSO and 1980 CET Mortality Tables

Sec. 38a-439-5. Purpose

The purpose of Sections 38a-439-6 to 38a-439-8, inclusive, is to permit individual life insurance policies to provide the same cash values and paid-up nonforfeiture benefits to both men and women. No change in minimum valuation standards is implied by this rule.

(Effective September 25, 1992)

Sec. 38a-439-6. Definitions

As used in Sections 38a-439-6 and 38a-439-7:

(a) "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 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 Factor.

(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.

(Effective September 25, 1992)

Sec. 38a-439-7. Rule

(a) For any policy of insurance on the life of either a male or female insured delivered or issued for delivery in this state on or after the date of election pursuant to Section 38a-439 (e) (11), a company may, for that policy form, substitute for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits: (1) a mortality table which is blend of the 1980 CSO Table (M) and the 1980 Table (F) with or without Ten-Year Select Mortality Factors 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) of this subsection but applied to form a blend of the 1980 CET Table (M) and the 1980 CET Table (F) in lieu of the 1980 CET Table.

(b) For purposes of the substitution authorized by subsection (a) of this section, the following tables will be considered as the basis for acceptable tables:

(1) 100% Male 0% Female for tables to be designated as the “1980 CSO-A” and “1980 CET-A” tables.

(2) 80% Male 20% Female for tables to be designated as the “1980 CSO-B” and “1980 CET-B” tables.

(3) 60% Male 40% Female for tables to be designated as the “1980 CSO-C” and “1980 CET-C” tables.

(4) 50% Male and 50% Female for tables to be designated as the “1980 CSO-D” and “1980 CET-D” tables.

(5) 40% Male 60% Female for tables to be designated as the “1980 CSO-E” and “1980 CET-E” tables.

(6) 20% Male 80% Female for tables to be designated as the “1980 CSO-F” and “1980 CET-F” tables.

(7) 0% Male 100% Female for tables to be designated as the “1980 CSO-G” and “1980 CET-G” tables.

The tables of subdivisions (1) and (7) of this subsection are not to be used with respect to policies issued on or after January 1, 1986 except where the proportion of persons insured is anticipated to be 90% or more of one sex or the other.

(Effective September 25, 1992)

Sec. 38a-439-8. Unfair discrimination

It shall not be a violation of Section 38a-815 of the Connecticut General Statutes for an insurer to issue the same kind of policy of life insurance on both a sex distinct and sex neutral basis.

(Effective September 25, 1992)

Sec. 38a-439-9. Separability

If any provision of this regulation 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.

(Effective September 25, 1992)

Sec. 38a-439-10. Purpose

The purpose of sections 38a-439-10 to 38a-439-15, inclusive, of the Regulations of Connecticut State Agencies, is to recognize, permit and prescribe the use of the 2001 Commissioners Standard Ordinary (CSO) Mortality Table for use in determining minimum nonforfeiture benefits in accordance with the Standard Nonforfeiture Law, subsection (e)(8)(C)(vi) of section 38a-439 of the Connecticut General Statutes.

(Adopted effective March 30, 2005)

Sec. 38a-439-11. Definitions

As used in sections 38a-439-10 to 38a-439-15, inclusive, of the Regulations of Connecticut State Agencies:

(a) “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, proposed to the National Association of Insurance Commissioners’ Life and Health Actuarial Task Force at its June 2002 meeting and adopted by the National Association of Insurance Commissioners in December 2002. The 2001 CSO Mortality Table is included in the Proceedings of the NAIC (2nd Quarter 2002). Unless the context indicates otherwise, the “2001 CSO Mortality Table” 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.

(b) “2001 CSO Mortality Table (F)” means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

(c) “2001 CSO Mortality Table (M)” means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

(d) “Composite mortality tables” means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

(e) “Smoker and nonsmoker mortality tables” means mortality tables with separate rates of mortality for smokers and nonsmokers.

(f) “Commissioner” means the Insurance Commissioner.

(Adopted effective March 30, 2005)

Sec. 38a-439-12. 2001 CSO mortality table

(a) At the election of the company for any one or more specified plans of insurance and subject to the conditions stated in section 38a-439-13 of the Regulations of Connecticut State Agencies, the 2001 CSO Mortality Table may be used as the

minimum standard for policies issued after April 1, 2005 and before the date specified in subsection (b) of this subsection to which subsection (d) of section 38a-78 of the Connecticut General Statutes and subsection (e)(8)(C)(vi) of section 38a-439 of the Connecticut General Statutes are applicable. If the company elects to use the 2001 CSO Mortality Table, it shall do so for both valuation and nonforfeiture purposes. With respect to domestic life insurers only, written notice of election to comply with the provisions of this subsection on or after a specified date shall be filed with the commissioner.

(b) Subject to the conditions stated in section 38a-439-13 of the Regulations of Connecticut State Agencies, the 2001 CSO Mortality Table shall be used in determining minimum standards for policies issued on and after January 1, 2009 to which subsection (d) of section 38a-78 of the Connecticut General Statutes and subsection (e)(8)(C)(vi) of section 38a-439 of the Connecticut General Statutes are applicable. (Adopted effective March 30, 2005)

Sec. 38a-439-13. Conditions

(a) For each plan of insurance with separate rates for smokers and nonsmokers an insurer may use:

(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 subsection (j) of section 38a-78 of the Connecticut General Statutes and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or

(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.

(Adopted effective March 30, 2005)

Sec. 38a-439-14. Gender-blended tables

(a) For any ordinary life insurance policy delivered or issued for delivery in this state after April 1, 2005 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 subsection.

(b) The company may choose from among the blended tables developed by the American Academy of Actuaries CSO Task Force, proposed to the National Association of Insurance Commissioners' Life and Health Actuarial Task Force at its June 2002 meeting and adopted by the National Association of Insurance Commissioners in December 2002. The proposed blended tables are included as

Appendix J-1 of the report of the CSO Task Force and are included in the Proceedings of the National Association of Insurance Commissioners (2nd Quarter 2002).

(c) It shall not, in and of itself, be a violation of section 38a-815 or 38a-816 of the Connecticut General Statutes for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis.

(Adopted effective March 30, 2005)

Sec. 38a-439-15. Separability

If any provision of sections 38a-439-10 to 38a-439-14, inclusive, of the Regulations of Connecticut State Agencies or its application to any person or circumstance is for any reason held to be invalid, the remainder of said sections and the application of the provision to other persons or circumstances shall not be affected.

(Adopted effective March 30, 2005)

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Accelerated Benefits of Life Insurance

Sec. 38a-457-1. Definitions

As used in Sections 38a-457-1 to 38a-457-11, inclusive:

(a) "Accelerated Benefits" mean benefits payable under a life insurance policy sold in this state:

(1) during the lifetime of the insured, in a lump sum or in periodic payments, as specified in the policy, provided upon the occurrence of a qualifying event as defined in subdivision (3) of subsection (c) of this section, no such benefits shall be payable in periodic payments;

(2) upon the occurrence of a qualifying event, as specified in the policy, and certified by a physician who is licensed under the laws of a state or territory of the United States, or such other foreign or domestic jurisdiction as the Commissioner may approve; and

(3) which reduce the death benefits otherwise payable under the life insurance policy.

(b) "Insurance policy" or "policy" means an insurance policy or certificate or rider or endorsement thereto.

(c) "Qualifying event" means:

(1) a medically determinable condition suffered by the insured which can be expected to result in death in a relatively short period of time, such as twelve months and may include, but is not limited to, coronary artery disease, myocardial infarction, stroke, kidney failure or liver disease; or

(2) a medical condition which would, in the absence of extensive or extraordinary medical treatment, result in death in a relatively short period of time, such as twelve months; or

(3) a medically determinable condition suffered by the insured which has caused the insured to be confined for at least six months in an institution which provides necessary care or treatment of an injury, illness or loss of functional capacity rendered by a certified or licensed health care provider in a setting other than an acute care hospital, and it has been medically determined that such insured is expected to remain confined in such institution until death.

(d) "Commissioner" means the Insurance Commissioner of the State of Connecticut.

(Effective October 23, 1992)

Sec. 38a-457-2. Type of product

(a) The risks insured under accelerated benefit riders and life insurance policies with accelerated benefit provisions shall be considered primarily mortality risks rather than morbidity risks; therefore, such riders and policies are considered to provide life insurance benefits.

(b) An accelerated benefits life insurance policy shall not include a policy providing for disability income protection coverage, or long term care coverage, as defined in Sections 38a-501 and 38a-528 of the General Statutes. For purposes of this subsection, disability income protection consisting of no more than \$20 per \$1,000 of coverage shall not constitute "a policy providing for disability income protection coverage."

(c) Death benefits may not be reduced more than the amount of the accelerated benefits paid plus any applicable actuarial discount appropriate to the policy design for policies without additional premium payments. When an accelerated benefit is paid, the amount paid may be considered as (1) a pro-rata reduction in cash value

or death benefits, or both, or (2) a lien against the death benefit of the contract and the access to the cash value shall be restricted to any excess of the cash value over the sum of other outstanding loans and the lien.

(d) The company may set a minimum benefit amount, but in no case shall it be more than 25 percent of the face value of the policy.

(e) The accidental death benefit, if any, in the policy shall not be affected by the payment of the accelerated benefit.

(Effective October 23, 1992)

Sec. 38a-457-3. Assignee beneficiary

Prior to the payment of the accelerated benefit, the insurer shall receive from any assignee or irrevocable beneficiary a signed acknowledgement of concurrence for payout.

(Effective October 23, 1992)

Sec. 38a-457-4. Criteria for payment

No restriction shall be permitted on the use of the proceeds payable under an accelerated benefits policy.

(Effective October 23, 1992)

Sec. 38a-457-5. Disclosures

(a) **Descriptive title.** The face of every accelerated benefits policy shall contain the following:

(1) a description of coverage which uses the terminology “accelerated”;

(2) the following statement: “Benefits as specified under this policy will be reduced upon receipt of an accelerated benefit.”

Accelerated benefits products shall not be described or marketed as long-term care insurance or as providing long-term care benefits.

(b) **Tax consequences.** Disclosure is required, at the time of application and at the time the accelerated benefits payment request is submitted, of the potential tax implications of receiving this payout. The disclosure statement shall indicate the extent to which the receipt of accelerated benefits may be taxable and that the insured should seek assistance from his personal tax advisor. Such disclosure shall be prominently displayed on the first page of the policy or rider in bold-face type or contrasting color.

(c) **Solicitations.**

(1) Prior to or concurrent with the application, the applicant shall be given a written disclosure including, but not limited to, a brief description of the accelerated benefit, the effect of the payment of an accelerated benefit on the policy’s cash value, death benefit, premium, policy loans and policy liens, and definitions of the conditions or occurrences triggering payment of the accelerated benefits. In the event of direct mail solicitation, the disclosure shall be made upon acceptance of the application.

(2) The insurer shall disclose in its solicitation any separate identifiable premium for the accelerated benefit. Those insurers indicating that this accelerated benefit is offered without additional premium shall furnish a written explanation to the Commissioner when filing the product for approval.

(3) Prior to or concurrent with the request for accelerated death benefits, the applicant shall be given an illustration demonstrating the effect of the payment of an accelerated benefit on the policy’s cash value, death benefit, premium, policy loans and policy liens.

(4) The insurer shall file with the Commissioner the information concerning the manner by which the actuarial discount and mortality charge, if any, is calculated for the accelerated benefit. The Commissioner, if he determines that such discount or mortality charge is excessive, shall hold a hearing to determine such reasonable charges.

(5) Any life insurance policy or any certificate, rider or endorsement thereto which provides accelerated benefits pursuant to the occurrence of a qualifying event as defined in section 38a-457-1 (c) (3) shall contain the following statement printed in a conspicuous and readily discernable manner: "This policy is not a long-term care policy as defined in Sections 38a-501 and 38a-528 of the Connecticut General Statutes."

(6) Ten-day free look. Any accelerated benefits rider which provides for any additional premium payments with an effective date subsequent to the effective date of the life insurance policy shall have printed thereon or attached thereto a notice stating, in substance, that the accelerated benefits rider may be returned by the insured for cancellation by delivering or mailing the rider to the insurer or to the insurance agent through whom it was effected, at any time within ten days after receipt of the rider by the insured, and that upon the delivery or mailing the rider shall be void ab initio.

(7) Effect of the benefit payment. When a policyowner or certificateholder requests an acceleration, the insurer shall send a statement to the policyowner or certificateholder, assignee 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. The statement shall disclose what adverse affect, if any, the actual or constructive receipt of accelerated benefit payments may have on the recipient's eligibility for Medicaid or other government benefits or entitlements. 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 policyowner or certificateholder, assignee and irrevocable beneficiary. When the insurer agrees to accelerate death benefits, the insurer shall issue a new or amended schedule page to the policy to reflect any new, reduced in-force face amount of the contract.

(Effective October 23, 1992)

Sec. 38a-457-6. Effective date of the accelerated benefits

The accelerated benefit provision for accidents shall be effective on the effective date of the policy or rider. The accelerated benefit provision in the case of illness shall be effective no more than thirty (30) days following the effective date of the policy or rider.

(Effective October 23, 1992)

Sec. 38a-457-7. Waiver of premiums

The accelerated benefit provision may or may not provide for the waiver of premium 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 requirements to keep the policy in force.

(Effective October 23, 1992)

Sec. 38a-457-8. Discrimination

Insurers shall not unfairly discriminate among insureds with similar qualifying events. Insurers shall not apply further conditions on the payment of the accelerated benefits other than those conditions specified in the policy or rider.

(Effective October 23, 1992)

Sec. 38a-457-9. Actuarial standards

(a) Financing options.

(1) The insurer may require a premium charge or cost of insurance charge, or

(2) The insurer may pay a present value of the face amount less any reasonable administrative expense charge. The calculation shall be based on any applicable actuarial discount appropriate to the policy design. The interest calculation shall be no greater than the maximum loan rate specified on currently issued policies, or

(3) The insurer may accrue an interest charge on the amount of the accelerated benefits at an interest rate no greater than the loan rate on currently issued policies.

(b) Effect on cash value.

(1) Except as provided in subdivision (2) of this subsection, when an accelerated benefit is payable, there shall be no more than a pro-rata reduction in the cash value based on the percentage of benefits accelerated.

(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 and the access to the cash value may be restricted to any excess of the cash value over the sum of any other outstanding loans and the lien. Future access to additional policy loans would also be limited to the excess of the cash value over the sum of the lien and any other outstanding policy loans.

(c) Effect of any outstanding policy loans on accelerated death benefit payment.

(1) When payment of any accelerated benefit results in a pro-rata reduction in the cash value, the payment may first be applied toward repaying a pro-rata portion of any outstanding policy loan.

(2) If the lien approach is used, any accelerated death benefit payment may first be applied toward repaying the portion of any other outstanding policy loans which cause the sum of the accelerated death benefit and policy loans to exceed the cash value.

(d) The death benefit may not be reduced more than the amount of the accelerated benefits adjusted for any applicable actuarial discount or accrued interest appropriate to the policy design plus any administrative expense charge for policies without additional payments.

(Effective October 23, 1992)

Sec. 38a-457-10. Reserves

At the time of the filing of the policy form, the valuation method and assumptions need to be filed with the Commissioner. The assumptions should reflect the mortality and interest rate assumptions for life insurance policies and appropriate assumptions for the other provisions incorporated in the policy form.

(Effective October 23, 1992)

Sec. 38a-457-11. Separability

If any provision of this regulation or the applicability thereof to any person or circumstance is held to be invalid, the remainder of this regulation or the applicability of such provision to other persons or circumstances shall not be affected thereby.

(Effective October 23, 1992)

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Life Insurance Providing Long-Term Care Benefits

Sec. 38a-458-1. Definition

As used in sections 38a-458-1 to 38a-458-12, inclusive:

(a) “Long-term care benefits” mean benefits payable under a life insurance policy:

(1) to a policyowner or certificateholder, during the lifetime of the insured upon the occurrence of confinement in a long-term care facility,

(2) which reduce the death benefit otherwise payable under the life insurance policy, and

(3) which are payable in periodic payments upon confinement.

(b) “Insurance policy” or “policy” means an insurance policy or certificate or rider or endorsement thereto.

(Effective April 27, 1992)

Sec. 38a-458-2. Type of product

The risks insured under long-term care benefits riders and life insurance policies with long-term care benefits provisions shall be considered primarily mortality risks rather than morbidity risks; therefore, such riders and policies are considered to provide life insurance benefits. In the absence of a contractual provision within the policy that payment of long-term care benefits will cease upon the termination of the policy, the long-term care benefits shall continue to be paid.

(Effective April 27, 1992)

Sec. 38a-458-3. Assignee/beneficiary

Prior to the payment of the long-term care benefits, the insurer shall receive from any assignee or irrevocable beneficiary a signed acknowledgement of concurrence for payout.

(Effective April 27, 1992)

Sec. 38a-458-4. Restrictions on use of proceeds

No restrictions shall be permitted on the use of the long-term care benefits proceeds.

(Effective April 27, 1992)

Sec. 38a-458-5. Disclosures

(a) **Descriptive title.** The face of a policy providing long-term care benefits shall contain the following:

(1) a description of coverage which uses the terminology “long-term care benefits”;

(2) the following statement: “Benefits as specified under this life insurance policy will be reduced upon receipt of long-term care benefits.”

(b) **Tax consequences.** Disclosure is required, at the time of application and at the time the long-term care benefits payment request is submitted, of the potential tax implications of receiving this payout. The disclosure statement shall indicate the extent to which the receipt of long-term care benefits may be taxable and that the insured should seek assistance from his personal tax advisor. Such disclosure shall be prominently displayed in bold-face type and contrasting color on the first page of the policy or rider and any other related documents.

(c) **Solicitations.** (1) Prior to or concurrently with the application, the applicant shall be given a written disclosure including, but not necessarily limited to, a brief description of the long-term care benefits and an explanation of any effect of the

payment of the benefits on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens. In the event of direct mail solicitations, the disclosure shall be made upon acceptance of the application.

(2) In addition, if there is a premium or cost of insurance charge, the applicant shall also be given a generic illustration numerically demonstrating any effect the payment of benefits will have on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens. In the event of direct mail solicitations, the disclosure shall be made at the time of solicitation or upon acceptance of the application.

(d) **Effect of the benefits payment.** When a policyowner or certificateholder requests long-term care benefits, the insurer shall send a statement to the policyowner, certificateholder, assignee and irrevocable beneficiary showing any effect that the payment of the long-term care benefits will have on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens. The statement shall disclose what adverse affect, if any, the actual or constructive receipt of the long-term care benefits payments may have on the recipient's eligibility for Medicaid or other government benefits or entitlements. When a previous disclosure statement becomes invalid as a result of a long-term care benefits payment, the insurer shall send a revised disclosure statement to the policyowner, certificateholder, assignee and irrevocable beneficiary. When the insurer agrees to pay long-term care benefits, the insurer shall issue a new or amended schedule page to the policy to reflect any new, reduced in-force face amount of the contract.

(Effective April 27, 1992)

Sec. 38a-458-6. Effective date of the long-term care benefits

The long-term care benefits provision shall be effective on the effective date of the rider or policy.

(Effective April 27, 1992)

Sec. 38a-458-7. Waiver of premium

The long-term care benefits provision may or may not provide for the waiver of premium in the absence of a regular waiver of premium provision being in effect. At the time that the benefits are claimed, the insurer shall explain any continuing premium requirement to keep the policy in force.

(Effective April 27, 1992)

Sec. 38a-458-8. Discrimination

Insurers shall not unfairly discriminate among insureds with respect to the eligibility for long-term care benefits. Insurers shall not apply further conditions on the payment of the long-term care benefits other than those conditions specified in the policy or rider.

(Effective April 27, 1992)

Sec. 38a-458-9. Financing options; cash values; policy loans; death benefits

(a) Financing options.

(1) The insurer may require a premium charge or cost of insurance charge; or

(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 calculation shall be no greater than the maximum loan rate specified on currently issued policies; or

(3) The insurer may accrue an interest charge on the amount of the long-term care benefits at an interest rate no greater than the loan rate on currently issued policies.

(b) Effect on cash value.

(1) Except as provided in subdivision (2) of this subsection, when long-term care benefits are payable, there shall be no more than a pro-rata reduction in the cash value based on the percentage of benefits payments.

(2) Alternatively, the payment of long-term care 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 and the access to the cash value may be restricted to any excess of the cash value over the sum of any other outstanding loans and the lien. Future access to additional policy loans would also be limited to the excess of the cash value over the sum of the lien and any other outstanding policy loans.

(c) Effect of any outstanding policy loans on long-term care benefits payment.

(1) When a payment of long-term care benefits results in a pro-rata reduction in the cash value, the payment may first be applied toward repaying a pro-rata portion of any outstanding policy loan.

(2) If the lien approach is used, any long-term care benefits payment may first be applied toward repaying the portion of any other outstanding policy loans which cause the sum of the long-term care benefits and policy loans to exceed the cash value.

(d) The death benefit may not be reduced more than the amount of the long-term care benefits adjusted for any applicable actuarial discount or accrued interest appropriate to the policy design plus any administrative expense charge for policies without additional payments. The accidental death benefit provision, if any, shall not be affected by the payment of the long-term care benefits.

(Effective April 27, 1992)

Sec. 38a-458-10. Reserves

At the time of filing of the policy form, the valuation method and assumptions shall be filed with the Insurance Department. The assumptions should reflect the statutory mortality and interest rate assumptions for life insurance policies and appropriate assumptions for the other provisions incorporated in the policy form.

(Effective April 27, 1992)

Sec. 38a-458-11. Other requirements

In addition to the preceding and where not inconsistent with the preceding, long-term care benefits riders and life insurance policies with long-term care benefits provisions shall comply with the requirements of the regulations promulgated under Sections 38a-501 and 38a-528 of the General Statutes.

(Effective April 27, 1992)

Sec. 38a-458-12. Separability

If any provision of this regulation 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.

(Effective April 27, 1992)

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Synthetic Guaranteed Investment Contracts

Sec. 38a-459-1. Scope and application

Sections 38a-459-1 to 38a-459-9, inclusive, of the Regulations of Connecticut State Agencies prescribe the terms and conditions in this State under which life insurance companies may issue group annuity contracts and other agreements that in whole or in part establish the insurance company's obligation by reference to a segregated portfolio of assets that is not owned by the insurance company; the essential operational features of the segregated portfolio of assets; and the reserve requirements for these group annuity contracts and agreements. In addition, sections 38a-459-1 to 38a-459-9, inclusive, of the Regulations of Connecticut State Agencies apply to that portion of a group annuity contract or other agreement described in section 38a-459-2(24) of the Regulations of Connecticut State Agencies and issued by a life insurance company functioning as an accounting record for an accumulation fund and having benefit guarantees relating to a principal amount and levels of interest at a fixed rate of return specified in advance. The fixed rates of return shall be constant over the applicable rate periods, and may reflect prior and current market conditions with respect to the segregated portfolio but may not reference future changes in market conditions. Any contract that has been approved by the insurance commissioner prior to June 1, 2002 need not be re-filed with the insurance commissioner.

(Adopted effective June 1, 2002)

Sec. 38a-459-2. Definitions

As used in sections 38a-459-1 to 38a-459-9, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Account assets" means the assets in the segregated portfolio plus any assets held in the general account or a separate account to meet the asset maintenance requirements.

(2) "Actuarial opinion and memorandum" means the opinion and memorandum of the valuation actuary required pursuant to section 38a-459-8(f) of the Regulations of Connecticut State Agencies.

(3) "Affirmatively approved" means approval of an insurance company's plan of operation for a class of contracts containing the form of contract under review, after the plan of operation associated with the class of contracts has been reviewed by the insurance company's domiciliary insurance department, and the plan of operation has been found to be in compliance with requirements substantially similar to those contained in sections 38a-459-1 to 38a-459-9 of the Regulations of Connecticut State Agencies by the domiciliary insurance department. Affirmatively approved does not mean approval as a result of an expiration of the time for review, such as when a plan of operation is "deemed approved" as set forth in sections 38a-459-3(c) or 38a-459-4(b) of the Regulations of Connecticut State Agencies.

(4) "Affiliate" means "affiliate" as defined in section 38a-1 of the Connecticut General Statutes.

(5) "Appointed actuary" means the qualified actuary appointed or retained either directly by or by the authority of the board of directors through an executive officer of the insurance company to prepare the annual statement of actuarial opinion for the insurance company as a whole pursuant to section 38a-78 of the Connecticut General Statutes.

(6) “Asset maintenance requirement” means the requirement to maintain assets to fund contract benefits in accordance with section 38a-459-8(a) of the Regulations of Connecticut State Agencies.

(7) “Class of contracts” means the set of all contracts to which a given plan of operation pertains.

(8) “Contract value record” means an accounting record, provided by the contract in relation to a segregated portfolio of assets, that is credited with a fixed rate of return over regular periods, and that is used to measure the extent of the insurance company’s obligation to the contract holder. The fixed rate of return credited to the contract value record is determined by means of a crediting rate formula or declared at the inception of the contract and valid for the entire term of the contract.

(9) “Crediting rate formula” means a mathematical formula used to calculate the fixed rate of return credited to the contract value record during any rate period and based in part upon the difference between the contract value record and the market value record amortized over an appropriate period. The fixed rate of return calculated by means of this formula may reflect prior and current market conditions with respect to the segregated portfolio, but shall not be based on future changes in market conditions.

(10) “Date of filing,” with respect to a filing for approval of a contract form, means the date the form is filed pursuant to section 38a-8-14 of the Regulations of Connecticut State Agencies.

(11) “Duration” means, with respect to the segregated portfolio assets or guaranteed contract liabilities, a measure of price sensitivity to changes in interest rates, such as the Macaulay duration or option-adjusted duration.

(12) “Fair market value” means a reasonable estimate of the amount that a buyer of an asset would be willing to pay, and a seller of an asset would be willing to accept, for the asset without duress in an arm’s length transaction. In the case of a publicly traded security, the fair market value is the price at which the security is traded or, if no price is available, a price that appropriately reflects the latest bid and asked prices for the security. In the case of a debt instrument that is not publicly traded, the fair market value is the discounted present value of the asset calculated at a reasonable discount rate. For all other non-publicly traded assets, fair market value shall be determined in accordance with valuation practices customarily used within the financial industry.

(13) “Guaranteed minimum benefits” means contract benefits on a specified date that shall be either:

(A) A principal guarantee, with or without a fixed minimum interest rate guarantee, related to the segregated portfolio;

(B) An assurance as to the future investment return or performance of the segregated portfolio; or

(C) The fair market value of the segregated portfolio, to the extent that the fair market value of the assets determines the contract holder’s benefits.

(14) “Hedging instrument” means:

(A)(i) An interest rate futures agreement or foreign currency futures agreement, an option to purchase or sell an interest rate futures agreement or foreign currency futures agreement, or any option to purchase or sell a security or foreign currency, used in a bona fide hedging transaction; or

(ii) A financial agreement or arrangement entered into with a broker, dealer, or bank qualified under applicable federal or state securities or banking law, in connection with investments in one or more securities in order to reduce the risk of changes

in market valuation or to create a synthetic investment that, when added to the portfolio, reduces the risk of changes in market valuation.

(B) An instrument shall not be considered a hedging instrument or a part of a bona fide hedging transaction if it is purchased in conjunction with another instrument where the effect of the combined transaction is an increase in the portfolio's exposure to market risk.

(15) "Investment guidelines" means a set of written guidelines, established in advance by the person with investment authority over the segregated portfolio, to be followed by the investment manager. The guidelines shall include a description of:

(A) The segregated portfolio's investment objectives and limitations;

(B) The investment manager's degree of discretion;

(C) The duration, asset class, quality, diversification, and other requirements of the segregated portfolio; and

(D) The manner in which derivative instruments may be used, if at all, in the segregated portfolio.

(16) "Investment manager" means the person (including the contract holder) responsible for managing the assets in the segregated portfolio in accordance with the investment guidelines in a fiduciary capacity to the owner of the assets.

(17) "Market value record" means an accounting record provided by the contract to reflect the fair market value of the segregated portfolio.

(18) "Permitted custodial institution" means a bank, trust company, or other corporate entity providing trust or custodial services.

(19) "Plan of operation" means a written plan meeting the requirements of section 38a-459-3(c) of the Regulations of Connecticut State Agencies.

(20) "Qualified actuary" means an individual who meets the qualification standards set forth in section 38a-53-1 of the Regulations of Connecticut State Agencies.

(21) "Rate period" means the period of time during which the fixed rate of return credited to the contract value record is applicable between crediting rate formula adjustments.

(22) "Segregated portfolio" means:

(A) A portfolio or sub-portfolio of assets to which the contract pertains that is held in a custody or trust account by the permitted custodial institution and identified on the records of the permitted custodial institution as special custody assets held for the exclusive benefit of the retirement plans or other entities on whose behalf the contract holder holds the contract; and

(B) Any related cash or currency received by the permitted custodial institution for the account of the contract holder and held in a deposit account for the exclusive benefit of the retirement plans or other entities on whose behalf the contract holder holds the contract.

(23) "Spot rate" corresponding to a given time of benefit payment means the yield on a zero-coupon, non-callable, non-indexed, and non-prepayable United States government obligation maturing at that time, or the zero-coupon yield implied by the price of a representative sampling of coupon-bearing, non-callable, non-indexed, and non-prepayable United States government obligations in accordance with a formula set forth in the plan of operation. If a zero-coupon, non-callable, non-indexed, and non-prepayable United States government obligation maturing at the time of payment does not exist, then the "spot rate" for such benefit payment shall be the yield on the zero-coupon, non-callable, non-indexed, and non-prepayable United States government obligation maturing at the date closest to the benefit payment or the yield determined through a methodology set forth in the plan of

operation designed to reach a comparable result. To the extent that guaranteed contract liabilities are denominated in the currency of a foreign country rated in one of the two highest rating categories by an independent, nationally-recognized United States rating agency acceptable to the insurance commissioner and are supported by investments denominated in the currency of the foreign country, the spot rate may be determined by reference to substantially similar obligations of the government of the foreign country. For liabilities other than those described in this subdivision, the spot rate shall be determined on a basis mutually agreed upon by the insurance company and the insurance commissioner.

(24) “Synthetic guaranteed investment contract” or “contract” means a group annuity contract or other agreement that in whole or in part establishes the insurance company’s obligations by reference to a segregated portfolio of assets that is not owned by the insurance company.

(25) “Unilateral contract termination event” means an event allowing the insurance company to unilaterally and immediately terminate the contract without future liability or obligation to the contract holder.

(26) “United States government obligation” means a direct obligation issued, assumed, guaranteed or insured by the United States or by an agency or instrumentality of the United States government.

(27) “Valuation actuary” means the appointed actuary or, alternatively, a qualified actuary designated by the appointed actuary to render the actuarial opinion. Written documentation of any such designation shall be on file at the insurance company and available for review by the insurance commissioner upon request.

(28) “Withdrawal hierarchy” means a protocol establishing the order of payment of amounts payable from the segregated portfolio and other funding arrangements other than at contract termination.

(Adopted effective June 1, 2002)

Sec. 38a-459-3. Financial requirements and plan of operation for synthetic guaranteed investment contracts

(a) A contract shall not be delivered or issued for delivery in this state unless the issuing insurance company is licensed to do life insurance business in this state pursuant to section 38a-41 of the Connecticut General Statutes and is financially qualified under the provisions of subsection (b) of this section. In addition, a domestic insurance company shall not deliver or issue for delivery, either in this state or outside this state, and an affiliate of a domestic insurance company shall not issue for delivery in this state a contract belonging to a specific class of contracts unless the insurance company has satisfied the requirements of subsection (c) of this section with respect to that class.

(b) An insurance company is financially qualified under this section if its most recent statutory financial statements reflect at least \$1 billion in admitted assets or \$100 million in capital and surplus, and its risk-based capital results do not trigger a regulatory action level event as set forth in section 38a-72-4 of the Regulations of Connecticut State Agencies. In lieu of the requirements in the preceding sentence, the insurance company may be required to satisfy such other financial qualification requirements set forth by the insurance commissioner as necessary or appropriate in a particular case to protect the insurance company’s policyholders or the public.

(c) A domestic insurance company satisfies the requirements of this section with respect to a class of contracts if the insurance company has filed a plan of operation pertaining to the class of contracts, together with copies of the forms of contract in the class, with the insurance commissioner and the filing of the plan of operation

has been approved or has not been disapproved within the sixty-day period following the date of filing, in which event the plan of operation shall be deemed approved. An affiliate of a domestic insurance company satisfies the requirements of this section with respect to a class of contracts if the insurance company has filed a plan of operations pertaining to the class of contracts, together with copies of forms of the contracts in the class, with the insurance commissioner and the filing has been approved, has not been disapproved, or the insurance commissioner has not provided to the affiliate in writing a detailed listing of all additional information necessary to make a determination on the filing within the thirty-day period following the date of the filing, in which event the plan of operations shall be deemed approved. If additional information is requested, the affiliate satisfies the requirements of this section once it has submitted a response to the insurance commissioner that to the best of the affiliate's knowledge and belief is responsive to the insurance commissioner's request and the filing, along with the response, has been approved or has not been disapproved within the thirty-day period following the date the response has been submitted, in which event the plan of operations shall be deemed approved. The plan of operation for a class of contracts shall describe the financial implications for the insurance company of the issuance of contracts in the class, and shall include at least the following:

(1) A statement that the plan of operation will be administered in accordance with the requirements prescribed by the insurance commissioner pursuant to sections 38a-459-1 to 38a-459-9, inclusive, of the Regulations of Connecticut State Agencies, along with a statement that the insurance company shall comply with the plan of operation in its administration of the contract;

(2) A statement describing the methods and procedures used to value statutory liabilities for purposes of section 38a-459-8 of the Regulations of Connecticut State Agencies;

(3) A description of the criteria used by the insurance company in approving the investment manager for the segregated portfolio of assets associated with a contract in the class, if the investment manager is an entity other than the insurance company or its wholly owned subsidiary;

(4) A description of the insurance company's requirement for reports concerning the assets in each segregated portfolio and transactions involving the assets, and a description of how the insurance company can use the information in a report to determine that the segregated portfolio is being managed in accordance with its investment guidelines. The insurance company shall require that the report be prepared no less frequently than quarterly, and include a complete statement of segregated portfolio holdings and their fair market value;

(5) A statement of the anticipated financial results for one or more sample contracts from the class of contracts, showing at a minimum the projected contract value records, the applicable fixed rate or rates of return, and the projected market value records, describing how the investments in the segregated portfolio reflect provision for benefits insured by the contract and how the contract value and market values and the rates of return may be affected by changes in the investment returns of the segregated portfolio and reasonably anticipated deposits to and withdrawals from the segregated portfolio by the contract holder, as well as any advances made by the insurance company to the contract holder. The sample contracts shall be chosen to reasonably represent the range of results that could be expected from possible combinations of contract provisions of all contracts within the class. The statement shall include at least three hypothetical return scenarios (level, increasing, and

decreasing) and for each of these scenarios, at least three withdrawal scenarios (zero, moderate, and high) shall be modeled. The insurance commissioner may require additional scenarios to fully understand the risks under the class of contracts. The period covered by the statement shall be the greater of five years or the minimum period the insurance company has to underwrite the risk;

(6) A statement that all contracts in the class of contracts satisfy the requirements regarding unilateral contract terminations of section 38a-459-7 of the Regulations of Connecticut State Agencies, together with a description of all termination events, discontinuation triggers and options, notice requirements, corrective action procedures, all other contract safeguards, and the procedures to be followed when a unilateral contract termination event occurs;

(7) A description of the allowable investment parameters (such as objectives, asset classes, quality, duration, and diversification requirements applied to the assets held within the segregated portfolio) to be reflected in the investment guidelines applicable to each contract issued in the class to which the submitted plan of operation applies; and a description of the procedures that shall be followed by the insurance company in evaluating the appropriateness of any specific investment guidelines submitted by the contract holder. If the insurance company chooses to operate a contract in accordance with investment guidelines not meeting the criteria established pursuant to this subdivision, the non-conforming set of investment guidelines shall be filed with the insurance commissioner in accordance with the filing requirements of this subsection;

(8) An unqualified opinion by a qualified actuary with expertise in such matters as to the adequacy of the consideration charged by the insurance company for the risks it has assumed with respect to the contracts in the class to which the plan of operation applies. A statement that the actuarial opinion and memorandum required pursuant to section 38a-459-8 of the Regulations of Connecticut State Agencies, with respect to the class of contracts to which the plan of operation applies, includes:

(A) If a payment has been made by the insurance company in the prior reporting period under a contract in the class, the amount of aggregate risk charges, i.e., the consideration charged by the insurance company for the risks it has assumed under the contract (net of administrative expenses, i.e., the amount of insurance company overhead or expense that is directly or indirectly allocable to a contract) for contracts in the class, and the aggregate amount of any losses incurred; and

(B) An inventory, by class of contracts, of all material events that could have, but did not, trigger a unilateral contract termination event by the insurance company during the prior reporting period and which have not been cured during the time period allowed for curing under the contract;

(9) A description of the withdrawal hierarchy, if any; and

(10) A statement that a review of the plan of operation by the insurance commissioner may necessitate requests for information pursuant to subsection (c) of this section.

(Adopted effective June 1, 2002)

Sec. 38a-459-4. Required contract provisions and filing requirements for synthetic guaranteed investment contracts

(a) A contract may not be delivered or issued for delivery in this state unless the contract satisfies the requirements of this subsection and the issuing insurance company has satisfied the requirements of subsection (b) of this section with respect to the contract. The contract shall:

(1) Provide that the assets to which the contract pertains and for which a contract value record is established will be maintained in a segregated portfolio of a permitted custodial institution;

(2) Grant the insurance company the right to perform audits and inspections of assets held in the segregated portfolio from time to time upon reasonable notice to the permitted custodial institution;

(3) Provide that the insurance company will receive prior notice of and the right to approve any appointment or change of investment managers;

(4) Give a description of how the contract value record will be determined, and, where applicable, adjusted by a crediting rate formula;

(5) State the maximum rate period between crediting rate formula recalculations that shall be permitted, if any;

(6) Provide the insurance company with the right to refuse to recognize any new deposits to the segregated portfolio unless there is a written agreement between the insurance company and the contract holder as to the permissible levels and timing of new deposits;

(7) Clearly identify all circumstances under which insurance company payments or advances to the contract holder are to be made;

(8) Clearly identify the types of withdrawals made on a market value basis;

(9) Provide either a fixed maturity schedule or a settlement option that permits the contract holder to receive the contract value record over time, provided that no unilateral contract termination event has occurred; and

(10) Include a provision stating, or substantially similar to, the following:

“No waiver of remedies by the insurance company that is a party to this agreement, following the breach of any contractual provision of the agreement or of the investment guidelines applicable to it, or failure to enforce the provisions or guidelines, which constitutes grounds for termination of this agreement for cause by the insurance company, and is not cured within 30 days following the insurance company’s discovery of it, shall be effective against the insurance commissioner in any future rehabilitation or insolvency proceedings against the insurance company unless approved in advance in writing by the insurance commissioner.”

(b) An insurance company satisfies the filing and approval requirements of this section with respect to a contract if the insurance company has filed the form of the contract with the insurance commissioner and it is accompanied by the items specified in subdivisions (1) to (3), inclusive, of this subsection, and the form has been approved or has not been disapproved within the thirty-day period following the date of filing, in which event the form of contract shall be deemed approved. Notwithstanding the provisions of this section, the requirement for filing and approval of the form of contract may be waived at the discretion of the insurance commissioner.

(1) The form of contract filed for approval shall be accompanied by a statement that the contract meets the conditions of subsection (a) of this section.

(2) The form of contract filed for approval shall be accompanied by a statement:

(A) Specifying the range of variation of variable contract provisions, if any, that could have a material effect on the risk assumed by the insurance company under the contract, including withdrawal methodology, crediting rate formula, and termination events;

(B) Describing how the fair market value shall be determined, including a description of the rules for valuing securities and other assets that are not publicly traded;

(C) Describing the crediting rate formula, if any, and how it shall operate to take into account the difference between the market value record and the contract value record over time; and

(D) Listing events that give the insurance company the right to terminate the contract immediately.

(3) (A) In the case where the plan of operation pertaining to the class of contracts to which the contract belongs has been affirmatively approved by the insurance commissioner of the state in which the issuing insurance company is domiciled, the form of contract filed for approval shall be accompanied by a statement indicating the receipt of approval, and that the approval was an affirmative approval.

(B) In the case where the plan of operation pertaining to the class of contracts to which the contract belongs has been deemed approved in the state in which the issuing insurance company is domiciled, the form of contract filed for approval shall be accompanied by a statement indicating that the issuing insurance company has met the requirements for deemed approval.

(C) In the case where the plan of operation pertaining to the class of contracts to which the contract belongs has not been approved in the state in which the issuing insurance company is domiciled, the form of contract filed for approval shall be accompanied by a statement of this fact, together with a plan of operation pertaining to the contract.

(Adopted effective June 1, 2002)

Sec. 38a-459-5. Investment management of the segregated portfolio

(a) The investment manager shall be responsible for, and have control over, the management of all segregated portfolio assets within the constraints specified in the investment guidelines.

(b) The investment guidelines shall be submitted to the insurance company for underwriting review before the contract becomes effective.

(c) If the insurance company accepts a proposed change to the investment guidelines or allows the contract to operate in accordance with investment guidelines not meeting the criteria established in the description of allowable investment parameters in section 38a-459-3(c)(7) of the Regulations of Connecticut State Agencies, approval of the non-conforming investment guidelines shall be requested pursuant to section 38a-459-3(c)(7) of the Regulations of Connecticut State Agencies.

(Adopted effective June 1, 2002)

Sec. 38a-459-6. Purchase of annuities from segregated account assets

For group annuity contracts, which make available to the contract holder the purchase of immediate or deferred annuities for the benefit of individual members of the group, an annuity may not be purchased without the delivery of the contractually agreed upon consideration in cash to the insurance company from the segregated portfolio for allocation to the insurance company's general account or a separate account. The insurance company shall collect adequate consideration for the cost of annuities purchased under contract option by transfer from the segregated portfolio.

(Adopted effective June 1, 2002)

Sec. 38a-459-7. Unilateral synthetic guaranteed investment contract terminations

A contract subject to sections 38a-459-1 to 38a-459-9, inclusive, of the Regulations of Connecticut State Agencies shall allow the insurance company to unilaterally and immediately terminate, without future liability of the insurance company or

obligation to provide further benefits, upon the occurrence of any one of the following events that is material and that is not cured within 30 days following the insurance company's discovery of it:

(1) The investment guidelines are changed without the advance consent of the insurance company and the investment manager is not controlling, controlled by, or under common control with the insurance company;

(2) The segregated portfolio, if managed by an entity that is not controlling, controlled by, or under common control with the insurance company, is invested in a manner that does not comply with the investment guidelines; or

(3) Investment discretion over the segregated portfolio is exercised by or granted to anyone other than the investment manager.

(Adopted effective June 1, 2002)

Sec. 38a-459-8. Reserves for synthetic guaranteed investment contracts

(a) An insurance company, at all times, shall hold minimum reserves in the general account or one or more separate accounts, as appropriate, equal to the excess, if any, of the value of the guaranteed contract liabilities, determined in accordance with subsections (f) and (g) of this section, over the market value of the assets in the segregated portfolio less the deductions provided for in subsection (b) of this section. The reserve requirements of this section shall be applied on a contract by contract basis.

(b) In determining compliance with the asset maintenance requirement and the reserve for guaranteed contract liabilities, the insurance company shall deduct a percentage of the market value of an asset as follows:

(1) For debt instruments, the percentage shall be the National Association of Insurance Commissioners asset valuation reserve "reserve objective factor," as set forth in the instructions for the National Association of Insurance Commissioners Annual and Quarterly Statement Blank, but the factor shall be increased by 50 percent for the purpose of this calculation if the difference in durations of the assets and liabilities is more than 184 days.

(2) For assets that are not debt instruments, the percentage shall be the National Association of Insurance Commissioners asset valuation reserve "maximum reserve factor," as set forth in the instructions for the National Association of Insurance Commissioners Annual and Quarterly Statement Blank.

(c) To the extent that guaranteed contract liabilities are denominated in the currency of a foreign country and are supported by segregated portfolio assets denominated in the currency of the foreign country, the percentage deduction for these assets shall be the percentage deduction for a substantially similar investment denominated in the currency of the United States.

(d) To the extent that guaranteed contract liabilities are denominated in the currency of the United States and are supported by segregated portfolio assets denominated in the currency of a foreign country, and to the extent that guaranteed contract liabilities are denominated in the currency of a foreign country and are supported by segregated portfolio assets denominated in the currency of the United States, the deduction for debt instruments shall be increased by 15 percent of the market value of the assets unless the currency exchange risk on the assets has been adequately hedged, in which case the percentage deduction shall be increased by one-half percent. No guaranteed contract liabilities denominated in the currency of a foreign country shall be supported by segregated portfolio assets denominated in the currency of another foreign country without the approval of the insurance

commissioner. For purposes of this section, the currency exchange risk on an asset is deemed adequately hedged if:

(1) It is an obligation of

(A) A jurisdiction rated in one of the two highest rating categories by an independent, nationally-recognized United States rating agency acceptable to the insurance commissioner;

(B) Any political subdivision or other governmental unit of such a jurisdiction, or any agency or instrumentality of a jurisdiction, political subdivision, or other governmental unit; or

(C) An institution that is organized under the laws of any such jurisdiction; and

(2) The principal amount of the obligation and scheduled interest payments on the obligation are hedged against the United States dollar pursuant to contracts or agreements that are:

(A) Issued by or traded on a securities exchange or board of trade regulated under the laws of the United States, Canada, or a province of Canada;

(B) Entered into with a United States banking institution that has assets in excess of \$5 billion and has obligations outstanding, or has a parent corporation that has obligations outstanding, rated in one of the two highest rating categories by an independent, nationally-recognized United States rating agency, or with a broker-dealer registered with the Securities and Exchange Commission that has net capital in excess of \$250 million; or

(C) Entered into with any other banking institution that has assets in excess of \$5 billion and that has obligations outstanding, or has a parent corporation that has obligations outstanding, rated in one of the two highest rating categories by an independent, nationally-recognized United States rating agency and that is organized under the laws of a jurisdiction that is rated in one of the two highest rating categories by an independent, nationally-recognized United States rating agency.

(e) A contract may provide for the allocation to one or more separate accounts of all or any portion of the amount needed to meet the asset maintenance requirement. If the contract provides that the assets in the separate account shall not be chargeable with liabilities arising out of any other business of the insurance company, the insurance company shall maintain in a distinct separate account that is so chargeable:

(1) That portion of the amount needed to meet the asset maintenance requirement that has been allocated to separate accounts; less

(2) The amounts contributed to separate accounts by the contract holder in accordance with the contract and the earnings on the contract.

(f) The minimum value of guaranteed contract liabilities is the sum of all expected guaranteed contract benefits, each discounted at a rate corresponding to the expected time of payment of the contract benefit that is not greater than the maximum multiple of the spot rate supportable by the expected return from the segregated portfolio assets, and in no event greater than 105 percent of the spot rate as described in the plan of operation (pursuant to section 38a-459-3 of the Regulations of Connecticut State Agencies) or the actuary's opinion and memorandum (pursuant to subsection (h) of this section), except that if the expected time of payment of a contract benefit is more than 30 years, it shall be discounted from the expected date of payment to year 30 at a rate of no more than 80 percent of the thirty year spot rate and from year 30 to the date of valuation at a rate not greater than 105 percent of the thirty year spot rate.

(g) In calculating the minimum value of guaranteed contract benefits:

(1) All guaranteed benefits potentially available to the contract holder on an ongoing basis shall be considered in the valuation process and analysis, and the reserve held has to be sufficient to fund the greatest present value of each independent guaranteed contract benefit. For purposes of this subdivision, the right granted to the contract holder to exit the contract by discharging the insurance company of its guarantee obligation under the contract and taking control of the assets in the segregated portfolio shall not be considered a guaranteed benefit.

(2) To the extent that future guaranteed cash flows are dependent upon the benefit responsiveness of an employer-sponsored plan, that is, the ability of a plan participant or contract owner to elect to receive a benefit or make an investment transfer, a best estimate based on insurance company experience or other reasonable criteria if insurance company experience is not available shall be used in the projections of future cash flows.

(h) An insurance company that issues a synthetic guaranteed investment contract subject to sections 38a-459-1 to 38a-459-9, inclusive, of the Regulations of Connecticut State Agencies shall submit an actuarial opinion and, upon request, a memorandum to the insurance commissioner annually by March 1 following the December 31 valuation date showing the status of the accounts as of the prior December 31. The actuarial opinion and memorandum shall be in form and substance satisfactory to the insurance commissioner.

(i) The actuarial memorandum required by subsection (h) of this section is a memorandum as set forth in subdivision (9) of section 38a-78(b) of the Connecticut General Statutes. The actuarial memorandum may include any matter required by section 38a-78 of the Connecticut General Statutes and is subject to the confidentiality protections of subdivision (11) of section 38a-78(b) of the Connecticut General Statutes.

(j) Except in cases of fraud or willful misconduct, the valuation actuary shall not be liable for damages to any person (other than the insurance company or the insurance commissioner) for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

(k) The statement of actuarial opinion submitted shall consist of:

(1) A paragraph identifying the valuation actuary and his or her qualification;

(2) A paragraph identifying the subjects on which the opinion is to be expressed and describing the scope of the valuation actuary's work;

(3) A paragraph describing those areas, if any, where the valuation actuary has deferred to other experts in developing data, procedures, or assumptions;

(4) A paragraph expressing the valuation actuary's opinion with respect to the matters described in section 38a-459-8(l) of the Regulations of Connecticut State Agencies; and

(5) One or more additional paragraphs as needed in individual insurance company cases as follows:

(A) If the valuation actuary considers it necessary to state a qualification of his or her opinion;

(B) If the valuation actuary has to disclose an inconsistency in the method of analysis used at the prior opinion date with that used for this opinion;

(C) If the valuation actuary chooses to add a paragraph briefly describing the assumptions that form the basis of the actuarial opinion.

(l) The actuarial opinion shall state that after taking into account any risk charge payable, the segregated portfolio assets, and the amount of any reserve liability with

respect to the asset maintenance requirement, the account assets make adequate provision for contract liabilities. The opinion shall also state:

(1) That reserves for contract liabilities are calculated pursuant to the requirements of section 38a-459-8(a) of the Regulations of Connecticut State Agencies;

(2) That after taking into account any reserve liability with respect to the asset maintenance requirement, the amount of the account assets satisfied the asset maintenance requirement;

(3) That the fixed-income segregated portfolio conformed to and justified the rates used to discount contract liabilities for valuation pursuant to section 38a-459-8(f) of the Regulations of Connecticut State Agencies;

(4) Whether rates used, pursuant to section 38a-459-8(f) of the Regulations of Connecticut State Agencies, to discount guaranteed contract liabilities and other items applicable to the segregated portfolio were modified from the rate or rates described in the plan of operation pursuant to section 38a-459-3 of the Regulations of Connecticut State Agencies; and

(5) That the level of risk charges, if any, retained in the general account was appropriate in view of such factors as the nature of the guaranteed contract liabilities and losses experienced in connection with account contracts and other pricing factors.

(m) The opinion shall be accompanied by a certificate of an officer of the insurance company responsible for monitoring compliance with the asset maintenance requirements for synthetic guaranteed investment contracts describing the extent to and manner in which, during the preceding year:

(1) Actual benefit payments conformed to the benefit payment estimated to be made as described in the plan of operation;

(2) The determination of the fair market value of the segregated portfolio conformed to the valuation procedures described in the plan of operation, including a statement of the procedures and sources used during the year; and

(3) Any assets were transferred to or from the insurance company's general account, or any amounts were paid to the insurance company by any contract holder to support the insurance company's guarantee.

(n) The actuarial memorandum shall:

(1) Substantially conform with those portions of section 38a-459-17 of the Regulations of Connecticut State Agencies that are applicable to asset adequacy testing and either:

(A) Demonstrate the adequacy of account assets based upon cash flow analysis, or

(B) Explain why cash flow testing analysis is not appropriate, describe the alternative methodology of asset adequacy testing used, and demonstrate the adequacy of account assets under that methodology;

(2) Describe the assumptions the valuation actuary used in support of the actuarial opinion, including any assumptions made in projecting cash flows under each class of assets, and any dynamic portfolio hedging techniques utilized and the tests performed on the utilization of the techniques. As used in this section, "dynamic portfolio hedging techniques" means techniques whereby an underlying portfolio of liabilities and their corresponding assets are hedged through the purchase or sale (owned or not owned by the hedger) of a hedging instrument, and such purchase or sale is managed so as to decrease the probability or severity of loss of the underlying portfolio due to changes in economic, market, insurable, or other events and the hedge is regularly adjusted or re-balanced through additional purchases or sales of assets, liabilities, or financial instruments (including options, futures, and

derivatives) at regular, small intervals as the risks and characteristics of the underlying portfolio change, in a manner that incorporates recent events;

(3) Describe how the valuation actuary has reflected the cost of capital;

(4) Describe how the valuation actuary has reflected the risk of default and downgrades on obligations and mortgage loans, including obligations and mortgage loans that are not investment grade;

(5) Describe how the valuation actuary has reflected withdrawal risks, if applicable, including a discussion of the positioning of the contracts within the withdrawal hierarchy pertaining to the contracts;

(6) If the plan of operation provides for investments in segregated portfolio assets other than United States government obligations, demonstrate that the rates used to discount contract liabilities accurately reflect expected investment returns, taking into account any foreign exchange risks;

(7) If the contracts provide that in certain circumstances they would cease to be funded by a segregated portfolio and instead become contracts funded by the general account, clearly describe how any increased reserves would be provided for if and to the extent these circumstances occurred;

(8) State the amount of account assets maintained in a separate account that are not chargeable with liabilities arising out of any other business of the insurance company;

(9) State the amount of reserves and supporting assets as of December 31 and where the reserves are shown in the annual statement;

(10) State the amount of any contingency reserve carried as part of surplus;

(11) State the market value of the segregated asset portfolio; and

(12) Where separate account assets are not chargeable with liabilities arising out of any other business of the insurance company, describe how the level of risk charges payable to the general account provides an appropriate compensation for the risk taken by the general account.

(o) When the insurance company issues a synthetic guaranteed investment contract complying with asset maintenance requirements it need not maintain an asset valuation reserve with respect to those account assets.

(p) Reserves for synthetic guaranteed investment contracts subject to sections 38a-459-1 to 38a-459-9, inclusive, of the Regulations of Connecticut State Agencies shall be an amount equal to the sum of the following:

(1) The amounts determined as the minimum reserve as required under subsection (a) of this section;

(2) Any additional amount determined by the insurance company's valuation actuary as necessary to make adequate provision for all contract liabilities; and

(3) Any additional amount determined as necessary by the insurance commissioner due to the nature of the benefits.

(q) The amount of any reserves required by this section shall be established by either:

(1) Allocating sufficient assets to one or more separate accounts; or

(2) Setting up the additional reserves in the general account.

(Adopted effective June 1, 2002)

Sec. 38a-459-9. Severability

If any provision of sections 38a-459-1 to 38a-459-9, inclusive, of the Regulations of Connecticut State Agencies or its application to any person or circumstance is 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.

(Adopted effective June 1, 2002)

Separate Accounts Funding Guaranteed Minimum Benefits Under Group Contracts

Sec. 38a-459-10. Scope and application

Sections 38a-459-10 to 38a-459-20, inclusive, of the Regulations of Connecticut State Agencies prescribes rules for separate accounts that fund guaranteed minimum benefits under group contracts. In addition, the regulation sets the procedures for establishing and maintaining these separate accounts and the reserve requirements for these accounts. The following requirements apply to group life insurance contracts, group annuity contracts, or funding agreements issued for delivery on or after June 1, 2002 if the contract is a group contract utilizing a separate account and providing guaranteed minimum benefits. However, for contracts issued on or before twenty-four months after June 1, 2002, the insurance company may continue to operate in accordance with the issued contract and plan of operations, if any, until such time as the applicable contract terms or provisions are substantially changed, at which time a filing in compliance with sections 38a-459-10 to 38a-459-20, inclusive, of the Regulations of Connecticut State Agencies shall be required. Sections 38a-459-10 to 38a-459-20, inclusive, of the Regulations of Connecticut State Agencies shall not apply to modified guaranteed annuities, modified guaranteed life insurance, variable annuities, variable life insurance, or equity index products but sections 38a-459-10 to 38a-459-20, inclusive, of the Regulations of Connecticut State Agencies shall apply to index contracts as defined in section 38a-459-11 of the Regulations of Connecticut State Agencies.

(Adopted effective June 1, 2002)

Sec. 38a-459-11. Definitions

As used in sections 38a-459-10 to 38a-459-20, inclusive, of the Regulations of Connecticut State Agencies:

(1) “Account assets” means separate account assets plus any assets held in the general account or a supplemental account utilized to meet the asset maintenance requirements.

(2) “Account contracts” means contracts providing guaranteed minimum benefits or other benefits and funded by a separate account and, if applicable, funded in part by the general account or a supplemental account in order to meet the asset maintenance requirements.

(3) “Actuarial opinion” means the opinion of the valuation actuary as required by section 38a-459-17 of the Regulations of Connecticut State Agencies.

(4) “Actuarial memorandum” means the memorandum of the valuation actuary required by section 38a-459-17 of the Regulations of Connecticut State Agencies.

(5) “Affiliate” means “affiliate” as defined in section 38a-1 of the Connecticut General Statutes.

(6) “Affirmatively approved” means approval of an insurance company’s plan of operation for a class of contracts containing the form of contract under review after the plan of operations associated with the class of contracts has been reviewed by the insurance company’s domiciliary insurance department or regulatory authority, and the plan of operations has been found to be in compliance with requirements substantially similar to those contained in sections 38a-459-10 to 38a-459-20 of the Regulations of Connecticut State Agencies. Affirmatively approved does not mean approval is ‘deemed approved’ as set forth in sections 38a-459-12(b) or (c), or 38a-459-13(b) of the Regulations of Connecticut State Agencies.

(7) “Appointed actuary” means the qualified actuary appointed or retained either directly by or by the authority of the board of directors through an executive officer of the insurance company to prepare the annual statement of actuarial opinion for the insurance company as a whole pursuant to section 38a-78 of the Connecticut General Statutes.

(8) “Asset maintenance requirements” means the requirement to maintain assets to fund contract benefits in accordance with sections 38a-459-14 to 38a-459-16, inclusive, of the Regulations of Connecticut State Agencies.

(9) “Book value contract” means a fixed accumulation contract, purchased through a retirement plan or deferred compensation plan, established or maintained by an employer, which contract does not participate in the investment experience of a separate account, with a fixed interest rate guarantee, including a guarantee based on an external index, and that is supported by a separate account, the plan of operations of which provides that the separate account’s assets are valued as if the assets were held in the insurance company’s general account.

(10) “Class of contracts” means the set of all contracts to which a given plan of operations pertains.

(11) “Contract” means a group life insurance policy, group annuity contract, or funding agreement that is within the scope of sections 38a-459-10 to 38a-459-20, inclusive, of the Regulations of Connecticut State Agencies as set forth in section 38a-459-10 of the Regulations of Connecticut State Agencies.

(12) “Contract benefits” means the amounts obligated to be paid by the insurance company under an account contract.

(13) “Contract liabilities” means the liabilities of the insurance company under account contracts, including liabilities with respect to which guarantees as to amount are provided by the insurance company and liabilities with respect to which guarantees as to amount are not provided by the insurance company.

(14) “Date of filing,” with respect to a filing for approval of a form of contract under sections 38a-459-10 to 38a-459-20, inclusive, of the Regulations of Connecticut State Agencies, means the date the form is filed pursuant to section 38a-8-14 of the Regulations of Connecticut State Agencies.

(15) “Derivative instrument” means an agreement, option, instrument, or a series or combination of them:

(A) To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or

(B) That has a price, performance, value, or cash flow based primarily upon the actual or expected price, level, performance, value, or cash flow of one or more underlying interests.

(C) Derivative instruments include options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures, and any other agreements, options, or substantially similar instruments, or any series or combination of them and any agreements, options, or other instruments permitted under sections 38a-102 to 38a-102i, inclusive, of the Connecticut General Statutes.

(16) “Duration” means, with respect to separate account or supplemental account assets or guaranteed contract liabilities, a measure of the price sensitivity of a stream of cash flows to interest rate movements, including, but not limited to, modified duration or option adjusted duration.

(17) “General account” means the assets of the insurance company other than separate account and supplemental account assets, and associated reserves.

(18) “Guaranteed minimum benefits” means benefits payable under the terms of the contract that are based on either subparagraph (C) or the greater of subparagraph (A) or (B):

(A) That part of the market value of account assets that determines the contract holder’s benefits, i.e., to the extent the assets are beneficially “client” assets; provided, that if asset performance does not determine the contract holder’s benefit, this subparagraph equals zero;

(B) A fixed minimum guarantee related to all or part of the considerations received under the contract;

(C) An amount based upon a publicly available interest rate series or an index of the aggregate market value of a group of publicly traded financial instruments, either of which is specified in the contract.

(19) “Hedging transaction” means a derivative transaction, involving the use of one or more derivative instruments, entered into and maintained to reduce: the risk of a change in the value, yield, price, cash flow, or quantity of assets or liabilities that the insurance company has acquired or incurred or anticipates acquiring or incurring; or the currency exchange risk or the degree of exposure as to assets or liabilities that an insurance company has acquired or incurred or anticipates acquiring or incurring; and other derivative transactions specified as hedging transactions in rules adopted by the insurance commissioner.

(20) “Index contract” means a contract under which benefits shall be based upon a publicly available interest rate series or an index of the aggregate market value of a group of publicly traded financial instruments, either of which is specified in the contract, and that does not provide a guarantee of some or all of the consideration received plus earnings at a fixed rate specified in advance and that does not provide any secondary guarantees on elective benefits or maturity values.

(21) “Market value separate account” means a separate account in which the account assets are valued at their market value.

(22) “Plan of operations” means a written plan meeting the requirements of section 38a-459-12 of the Regulations of Connecticut State Agencies.

(23) “Qualified actuary” means an individual who is qualified to sign statements of actuarial opinion in accordance with the qualification standards set forth in section 38a-53-1 of the Regulations of Connecticut State Agencies.

(24) “Separate account” means an account established pursuant to section 38a-433 or 38a-459 of the Connecticut General Statutes.

(25) “Spot rate” corresponding to a given time of benefit payment means the yield on a zero-coupon, non-callable, non-indexed, and non-prepayable United States government obligation maturing at that time, or the zero-coupon yield implied by the price of a representative sampling of coupon-bearing, non-callable, non-indexed, and non-prepayable United States government obligations, in accordance with a formula set forth in the plan of operations. If a zero-coupon, non-callable, non-indexed, and non-prepayable United States government obligation maturing at the time of payment does not exist, then the “spot rate” for such benefit payment shall be the yield on the zero-coupon, non-callable, non-indexed, and non-prepayable United States government obligation maturing at the date closest to the benefit payment or the yield determined through a methodology set forth in the plan of operation designed to reach a comparable result. To the extent that guaranteed contract liabilities are denominated in the currency of a foreign country rated in one of the two highest rating categories by an independent, nationally-recognized United States rating agency acceptable to the insurance commissioner and are

supported by investments denominated in the currency of the foreign country, the spot rate may be determined by reference to substantially similar obligations of the government of the foreign country. For liabilities other than those described in this subdivision, the spot rate shall be determined on a basis mutually agreed upon by the insurance company and the insurance commissioner.

(26) “Supplemental account” means a separate account established pursuant to sections 38a-459-14 to 38a-459-16, inclusive, of the Regulations of Connecticut State Agencies to which assets may be contributed by the insurance company for the purpose of complying, in whole or in part, with the asset maintenance requirement and with respect to which neither the account contracts nor applicable law shall provide that the assets of the supplemental account are not chargeable with liabilities arising out of any other business of the insurance company.

(27) “United States government obligation” means a direct obligation issued, assumed, guaranteed, or insured by the United States or by an agency or instrumentality of the United States.

(28) “Valuation actuary” means the appointed actuary or, alternatively, a qualified actuary designated by the appointed actuary to render the actuarial opinion. Written documentation of any such designation shall be on file at the insurance company and available for review by the insurance commissioner upon request.

(Adopted effective June 1, 2002)

Sec. 38a-459-12. Plan of operations requirements for separate accounts supporting book value contracts

(a) A contract may not be delivered or issued for delivery in this state unless the issuing insurance company is licensed to do life insurance business in this state pursuant to section 38a-41 of the Connecticut General Statutes. In addition,

(1) A domestic insurance company may not deliver or issue for delivery, either in this state or outside this state, a contract belonging to a specific class of contracts unless the insurance company has satisfied the requirements of subsection (b) of this section with respect to that class; and

(2) An affiliate of a domestic insurance company may not deliver or issue for delivery in this state a contract belonging to a specific class of contracts unless the insurance company has satisfied the requirements of subsection (c) of this section with respect to that class.

(b) A domestic insurance company satisfies the requirements of this section if the insurance company has filed a plan of operations pertaining to the class of contracts, together with copies of forms of the contracts in the class, with the insurance commissioner and the filing has been approved or has not been disapproved within a sixty-day period following the date of the filing, in which event the plan of operations shall be deemed approved.

(c) An affiliate of a domestic insurance company satisfies the requirements of this section if the insurance company has filed a plan of operations pertaining to the class of contracts, together with copies of forms of the contracts in the class, with the insurance commissioner and the filing has been approved, has not been disapproved, or the insurance commissioner has not provided to the affiliate in writing a detailed listing of all additional information necessary to make a determination on the filing within a thirty-day period following the date of the filing, in which event the plan of operations shall be deemed approved. In the situation where additional information is requested, the affiliate satisfies the requirements of this section once it has submitted a response to the insurance commissioner that to the best of the affiliate’s knowledge and belief is responsive to the insurance commissioner’s

request and the filing, along with the response, has been approved or has not been disapproved within a thirty-day period following the date the response has been submitted, in which event the plan of operations shall be deemed approved.

(d) The plan of operations for a class of contracts shall describe the financial implications for the insurance company of the issuance of contracts in the class, and shall include at least the following:

(1) A description of the class of contracts to which the plan of operations pertains, including a description of the products, the markets to which the products will be sold, and the benefits that are being offered (including whether those benefits will be paid on a market or book value basis);

(2) A statement that the plan of operations shall be administered in accordance with the requirements prescribed by the insurance commissioner pursuant to sections 38a-459-10 to 38a-459-20, inclusive, of the Regulations of Connecticut State Agencies, along with a statement that the insurance company shall comply with the plan of operations in its administration of the contract;

(3) A statement of the investment policy for the separate account and any supplemental account, including requirements for diversification, maturity, type and quality of assets, and, as applicable, target duration for matching guaranteed contract liabilities or the degree to which the investment policy is likely to match the performance of an interest rate series or index on which contract benefits are based;

(4) A description of how the value of the separate account assets and any supplemental account is to be determined, including but not limited to, a statement of procedures and rules for valuing securities and other assets that are not publicly traded;

(5) A description of how the guaranteed contract liabilities are to be valued, including, if applicable, with respect to guaranteed minimum benefits or other benefits, a description of the methodology for calculating spot rates and the rates proposed to be used to discount guaranteed contract liabilities if higher than the applicable spot rates, but the rate or rates used shall not exceed 105 percent of the spot rate, except that if the expected time of payment of a contract benefit spans more than 30 years, the guaranteed minimum benefits or other benefits shall be discounted from the expected time of payment to year 30 at a rate of no more than 80 percent of the thirty year spot rate and from year 30 to the date of valuation at a rate not greater than 105 percent of the thirty year spot rate, and shall accurately reflect expected investment returns (taking into account foreign exchange risks);

(6) A statement of how the separate account's operations are designed to provide for payment of contract benefits as they become due, including but not limited to:

(A) A description of the method for estimating the amount and timing of benefit payments;

(B) The arrangements necessary to provide liquidity to cover contingencies;

(C) The method to be used to comply with the asset maintenance requirement;

(D) The manner in which account assets shall be allocated between the separate account, any supplemental account, and the general account;

(E) If applicable, the deductions to be used in determining the market value of an asset when determining the asset maintenance requirement when the investment policy of the separate account and any supplemental accounts is not likely to match the performance of an interest rate series or index on which contract benefits are based; and

(F) For index contracts, the deductions to be used for replicated (synthetic asset) transactions in determining the market value of the separate account.

(7) An unqualified opinion by a qualified actuary with expertise in such matters as to the adequacy of the consideration charged by the insurance company for the risks it has assumed with respect to the contracts in the class to which the plan of operations pertains;

(8) If hedging transactions are to be utilized in managing separate account or any supplemental account assets, a description of the instruments and techniques and an explanation of how they are intended to reduce risk of loss;

(9) If the amount of the asset maintenance requirement depends on the separate account, any supplemental account or a subportfolio of either being duration matched, a description of the method used to determine the durations of separate account and any supplemental account assets and guaranteed contract liabilities;

(10) If a part of the asset maintenance requirement is to be met by maintaining a reserve liability in the general account, a description of:

(A) The circumstances under which increases and decreases in the general account portion of the reserve liability shall be made;

(B) The circumstances under which transfers shall be made between the separate account and the general account; and

(C) Any arrangements needed to provide sufficient liquidity in the general account to enable the insurance company to make transfers to the separate account when due.

(11) A statement as to the extent to which the contracts in the class shall provide that the separate account assets shall not be chargeable with liabilities arising out of any other business of the insurance company; and

(12) If any person other than the insurance company may authorize, approve, or review the acquisition and disposition of investments for the separate account or any supplemental account, a statement of the safeguards adopted by the insurance company to assure that the actions to be taken by these persons are appropriate, including a description of the criteria used by the insurance company in selecting the person.

(e) Notwithstanding the descriptions in the plan of operations, the insurance company may change the rate utilized, pursuant to section 38a-459-14(f) of the Regulations of Connecticut State Agencies, to discount guaranteed contract liabilities and other items applicable to the separate account or any supplemental accounts, provided that the rates used shall not exceed 105 percent of the spot rate, except that if the expected time of payment of a contract benefit is more than 30 years, the guaranteed contract liabilities and other items applicable to the separate account or any supplemental accounts shall be discounted from the expected time of payment to year 30 at a rate of no more than 80 percent of the thirty year spot rate and from year 30 to the date of valuation at a rate not greater than 105 percent of the thirty year spot rate, and shall accurately reflect expected investment returns (taking into account any exchange risks). Any such change shall be disclosed and justified in the actuarial opinion.

(f) The plan of operations may provide that the separate account shall fund guaranteed contract liabilities denominated in the currency of a foreign country with separate account and any supplemental account assets denominated in that currency, provided that at the time of issuance of the account contracts the country is rated in one of the two highest rating categories by an independent, nationally-recognized United States rating agency acceptable to the insurance commissioner.

(g) The insurance commissioner, at his or her discretion, may require an insurance company to file additional information as part of the plan of operations upon a determination that the plan of operations is insufficient.

(Adopted effective June 1, 2002)

Sec. 38a-459-13. Contract provisions and filing requirements for separate accounts supporting book values under group contracts

(a) A contract may not be delivered or issued for delivery in this state unless the contract satisfies the following requirements. The contract shall provide:

(1) A description of any contractual safeguards that ensure asset sufficiency, including termination events, discontinuance triggers, or discontinuance options and corrective action procedures;

(2) A description of how charges under the contract are computed, including, but not limited to, risk or surrender charges; and

(3) For a book value contract, a description of how any market value adjustments under the contract are computed.

(b) An insurance company satisfies the filing and approval requirements with respect to a contract if the insurance company has filed the form of the contract with the insurance commissioner, it is accompanied by the items contained within subdivisions (1) to (3), inclusive, of this subsection, and the form of contract has been approved or has not been disapproved within a thirty-day period following the date of filing, in which event the form of contract shall be deemed approved. Notwithstanding the provisions of this section, the requirement for filing and approval of the form of contract may be waived at the discretion of the insurance commissioner.

(1) The form of the contract filed for approval shall be accompanied by a statement that the contract meets the conditions of subsection (a) of this section.

(2) The form of contract filed for approval shall be accompanied by a statement:

(A) Specifying the range of variation of variable contract provisions, if any, that could have a material effect on the risk assumed by the insurance company under the contract, including withdrawal methodology, crediting rate formula, and termination events; and

(B) A statement listing events, if any, that give the insurance company the right to terminate the contract immediately.

(3) (A) If the plan of operations pertaining to the class of contracts to which the contract belongs has been affirmatively approved by the insurance commissioner of the state in which the issuing insurance company is domiciled, the form of a contract filed for approval shall be accompanied by a statement indicating the receipt of approval and that the approval was an affirmative approval; or

(B) If the plan of operations pertaining to the class of contracts to which the contract belongs has been deemed approved in the state in which the issuing insurance company is domiciled, the form of contract filed for approval shall be accompanied by a statement indicating that the issuing insurance company has met the requirements for deemed approval; or

(C) If the plan of operations pertaining to the class of contracts to which the contract belongs has not been approved in the state in which the issuing insurance company is domiciled, the form of contract filed for approval shall be accompanied by a statement of this fact, together with a plan of operations pertaining to the contract.

(D) If the plan of operations pertaining to the class of contracts to which the contract belongs has not been approved in the state of domicile of the issuing insurance company, the insurance commissioner, in issuing contract approvals, shall require that the contract be operated in compliance with the plan of operations in order to maintain its approval.

(Adopted effective June 1, 2002)

Sec. 38a-459-14. Asset maintenance requirements for market value separate accounts supporting contracts other than index contracts

(a) An insurance company shall hold sufficient assets as a reserve in the general account, separate account, or supplemental accounts, as appropriate, such that the market value of the assets held in the separate account, plus the market value of any supplemental account, plus assets held in the general account as a reserve for guaranteed contract liabilities (valued in accordance with section 38a-78 of the Connecticut General Statutes), less the deductions provided for in subsection (b) of this section, equals or exceeds the value of guaranteed contract liabilities determined in accordance with subsection (f) of this section.

(b) In determining compliance with the asset maintenance requirement and the reserve for guaranteed contract liabilities, the insurance company shall deduct a percentage of the market value of the separate account or supplemental account asset or an amount attributable to a replicated (synthetic asset) transaction as follows:

(1) For debt instruments, the percentage shall be the National Association of Insurance Commissioners asset valuation reserve "reserve objective factor," as set forth in the instructions for the National Association of Insurance Commissioners Annual and Quarterly Statement Blank, but the factor shall be increased 50 percent for the purpose of this subdivision if the difference in durations of the assets and liabilities is more than 184 days;

(2) For assets that are not debt instruments, the percentage shall be the National Association of Insurance Commissioners asset valuation reserve "maximum reserve factor," as set forth in the instructions for the National Association of Insurance Commissioners Annual and Quarterly Statement Blank; and

(3) For replicated (synthetic asset) transactions, the market value of the separate account or supplemental account assets shall be decreased by an amount equal to the asset valuation reserve for the transaction as if the transaction were occurring in the general account, determined in accordance with section 38a-78 of the Connecticut General Statutes; but to the extent that the National Association of Insurance Commissioners asset valuation reserve maximum reserve factor, as set forth in the instructions for the National Association of Insurance Commissioners Annual and Quarterly Statement Blank, was not used in determining the amount of the deduction, the amount of the deduction shall be increased 50 percent for purposes of this subdivision.

(c) To the extent that guaranteed contract liabilities are denominated in the currency of a foreign country and are supported by separate account or supplemental account assets denominated in the currency of the foreign country, the percentage deduction for these assets shall be the percentage deduction for a substantially similar investment denominated in the currency of the United States.

(d) To the extent that guaranteed contract liabilities are denominated in the currency of the United States and are supported by separate account or supplemental account assets denominated in the currency of a foreign country, and to the extent that guaranteed contract liabilities are denominated in the currency of a foreign country and are supported by separate account or supplemental account assets denominated in the currency of the United States, the deduction for debt instruments and replicated (synthetic assets) transactions shall be increased by 15 percent of its market value unless the currency exchange risk has been adequately hedged, in which case the percentage deduction shall be increased by one-half percent. No guaranteed contract liabilities denominated in the currency of a foreign country shall be supported by separate account or supplemental account assets denominated in

the currency of another foreign country without the approval of the insurance commissioner. For purposes of this subsection, the currency exchange rate on an asset is deemed adequately hedged if:

(1) It is an obligation of a jurisdiction that is rated in one of the two highest rating categories by an independent, nationally-recognized United States rating agency acceptable to the insurance commissioner or other governmental unit of the jurisdiction, or is organized under the laws of the jurisdiction; and

(2) At all times, the principal amount and scheduled interest payments on the principal are hedged against the United States dollar pursuant to contracts or agreements that are:

(A) Issued by or traded on a securities exchange or board of trade regulated under the laws of the United States, Canada, or a province of Canada;

(B) Entered into with a United States banking institution that has assets in excess of \$5 billion and has obligations outstanding, or has a parent corporation that has obligations outstanding, rated in one of the two highest rating categories by an independent, nationally-recognized United States rating agency, or with a broker-dealer registered with the Securities and Exchange Commission that has net capital in excess of \$250 million;

(C) Entered into with any other banking institution that has assets in excess of \$5 billion and that has obligations outstanding, or has a parent corporation that has obligations outstanding, rated in one of the two highest rating categories by an independent, nationally-recognized United States rating agency and that is organized under the laws of a jurisdiction that is rated in one of the two highest rating categories by an independent, nationally-recognized United States rating agency; or

(D) Entered into with an entity permitted under Title 38a of the Connecticut General Statutes enumerating permitted counterparties for currency hedging transactions.

(e) All or a portion of the amount needed to comply with the asset maintenance requirement may be allocated to one or more supplemental accounts. If the account contract or applicable law provides that the assets in the separate account shall not be chargeable with liabilities arising out of any other business of the insurance company, the insurance company shall maintain in a supplemental account or the general account the amount of any account assets in excess of the sum of the amounts contributed (net of withdrawals) by the contract holder, and the earnings attributable to the amounts contributed (net of withdrawals) by the contract holder.

(f) For purposes of this section, the minimum value of guaranteed contract liabilities is defined to be the sum of the expected guaranteed contract benefits, each discounted at a rate corresponding to the expected time of payment of the contract benefit that is not greater than the maximum multiple of the spot rate supportable by the expected return from the separate account and any supplemental account assets provided that the rate used shall not exceed 105 percent of the spot rate, except that if the expected time of payment of a contract benefit is more than 30 years, the expected guaranteed contract benefits shall be discounted from the expected time of payment to year 30 at a rate of no more than 80 percent of the thirty year spot rate and from year 30 to the date of valuation at a rate not greater than 105 percent of the thirty year spot rate, and shall accurately reflect expected investment returns (taking into account any exchange risks) or as described in the actuarial opinion. In calculating the minimum value of contract benefits, all guaranteed contract benefits potentially available to the contract holder shall be considered in the valuation process and analysis, and the reserve held shall be sufficient to fund the greatest

present value of each independent guaranteed benefit stream, including guaranteed annuitization options available. To the extent that future cash flows are dependent upon the benefit responsiveness features of an employer-sponsored plan, a best estimate or an estimate based on the insurance company's experience shall be used in the projections of the future cash flows. In addition, the valuation actuary shall periodically review the actual experience under the contract to validate the assumptions used. In projecting cash flows for contingent benefits involving mortality, mortality tables for these benefits prescribed or authorized by applicable law shall be utilized.

(Adopted effective June 1, 2002)

Sec. 38a-459-15. Asset maintenance requirements for market value separate accounts supporting index contracts

(a) An insurance company shall hold sufficient assets as a reserve in the general account, the separate account, or supplemental accounts, as appropriate, such that the market value of the assets held in the separate account, plus the market value of any supplemental account, plus any assets held in the general account as a reserve for guaranteed contract liabilities (valued in accordance with section 38a-78 of the Connecticut General Statutes), less any deduction provided for in subsection (b) of this section, equals or exceeds the value of guaranteed contract liabilities determined in the manner set forth in the plan of operations.

(b) In determining compliance with the asset maintenance requirement and the reserves for guaranteed contract liabilities, the insurance company shall deduct a percentage of the market value of a separate account or supplemental account asset as set forth in the plan of operations, and for replication (synthetic asset) transactions, the value of the separate account or supplemental account assets shall be decreased in the manner set forth in the plan of operations.

(c) All or a portion of the amount needed to comply with the asset maintenance requirement may be allocated to one or more supplemental accounts. If the account contract or applicable law provides that the assets in the separate account shall not be charged with liabilities arising out of any other business of the insurance company, the insurance company shall maintain in a supplemental account or the general account the amount of any account assets in excess of the sum of the amounts contributed (net of withdrawals) by the contract holder and the earnings attributable to the amounts contributed (net of withdrawals) by the contract holder.

(Adopted effective June 1, 2002)

Sec. 38a-459-16. Asset maintenance requirements for separate account supporting book value contracts

(a) An insurance company, at all times, shall hold sufficient assets in the general account, the separate account, or supplemental accounts, as appropriate, such that the value of the account assets, valued as if the assets were held in the insurance company's general account, equals or exceeds the reserve required for contracts supported by the separate account, determined as if the contracts were held in the general account.

(b) All or any portion of the amount needed to comply with the asset maintenance requirement may be allocated to one or more supplemental accounts. If the account contract or applicable law provides that the assets in the separate account shall not be chargeable with liabilities arising out of any other business of the insurance company, the insurance company shall maintain in a supplemental account or the general account the amount of any account assets in excess of the sum of the

amounts contributed (net of withdrawals) by the contract holder, and the earnings attributable to the amounts contributed (net of withdrawals) by the contract holder.

(Adopted effective June 1, 2002)

Sec. 38a-459-17. Actuarial opinion and memorandum for separate accounts supporting book values under group contracts

(a) An insurance company that maintains any separate accounts governed by sections 38a-459-10 to 38a-459-20, inclusive, of the Regulations of Connecticut State Agencies shall submit an actuarial opinion rendered by the valuation actuary to the insurance commissioner annually by March 1 showing the status of the accounts as of the preceding December 31. The actuarial opinion shall be supported by an actuarial memorandum prepared by the valuation actuary rendering the opinion. The valuation actuary may be either the appointed actuary of the insurance company or, alternatively, a qualified actuary designated by the appointed actuary to be the valuation actuary for the purpose of sections 38a-459-10 to 38a-459-20, inclusive, of the Regulations of Connecticut State Agencies.

(b) The actuarial memorandum required by subsection (h) of this section is a memorandum as set forth in subdivision (9) of section 38a-78(b) of the Connecticut General Statutes. The actuarial memorandum may include any matter required by section 38a-78 of the Connecticut General Statutes and is subject to the confidentiality protections of subdivision (11) of section 38a-78(b) of the Connecticut General Statutes.

(c) Except in cases of fraud or willful misconduct, the valuation actuary shall not be liable for damages to any person (other than the insurance company or the insurance commissioner) for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

(d) The statement of actuarial opinion, submitted pursuant to subsection (a) of this section, shall cover the applicable points set forth in sections 38a-78-1 to 38a-78-9, inclusive, of the Regulations of Connecticut State Agencies and at a minimum consist of:

(1) A paragraph identifying the valuation actuary and their qualifications;

(2) A scope paragraph identifying the subjects on which the opinion is to be expressed and describing the scope of the valuation actuary's work;

(3) A paragraph describing those areas, if any, where the valuation actuary deferred to other experts in developing data, procedures, or assumptions supported by a statement of each expert in the form prescribed by section 38a-78-7 of the Regulations of Connecticut State Agencies; and

(4) A paragraph expressing the valuation actuary's opinion that, after taking into account any risk charge payable from the separate account assets and the amount of any reserve liability of the general account and amounts held in any supplemental account with respect to the asset maintenance requirement, the account assets make adequate provision for the contract liabilities.

(5) The opinion shall also state:

(A) That the level of risk charges, if any, payable to the general account was appropriate in view of such factors as the nature of the guaranteed contract liabilities and losses experienced in connection with account contracts, and other pricing factors;

(B) That after taking account of any reserve liability of the general account and amounts held in any supplemental account with respect to the asset maintenance requirement, the amount of the account assets satisfied the asset maintenance requirement;

(C) That the fixed-income asset portfolio conformed to, and justified, the rates used to discount contract liabilities for valuation, if applicable; and

(D) Whether any rates utilized, pursuant to section 38-459-14(f) of the Regulations of Connecticut State Agencies, to discount guaranteed contract liabilities and other items applicable to the separate account or any supplemental account were modified from the rate or rates described in the plan of operations.

(6) One or more additional paragraphs may be needed in individual insurance company cases as follows:

(A) If the valuation actuary considers it necessary to state a qualification of his opinion;

(B) If the valuation actuary has to disclose an inconsistency in the method of analysis used at the prior opinion date with that used for this opinion; or

(C) If the valuation actuary chooses to add a paragraph briefly describing the assumptions which form the basis of the actuarial opinion.

(e) The opinion shall be accompanied by a certificate of an officer of the insurance company responsible for monitoring compliance with the asset maintenance requirements for the separate accounts, describing the extent to and manner in which during the preceding year:

(1) Actual benefit payments conformed to the benefit payment estimated to be made as described in the plan of operations;

(2) The determination of the value of the separate account and any supplemental account conformed to the valuation procedures described in the plan of operations, including, but not limited to, a statement of the procedures and sources of information used during the year; and

(3) Any assets were transferred to or from the insurance company's general account, or any amounts were paid to the insurance company by any contract holder to support the insurance company's guarantee.

(f) The actuarial memorandum shall:

(1) Substantially conform with those portions of section 38a-78-9 of the Regulations of Connecticut State Agencies applicable to asset adequacy testing and:

(A) Demonstrate the adequacy of account assets based upon cash flow analysis; or

(B) Explain why cash flow analysis is not appropriate, describe the alternative methodology of asset adequacy testing used, and demonstrate the adequacy of account assets under such methodology;

(2) Describe the assumptions the valuation actuary used in support of the actuarial opinion, including any assumptions made in projecting cash flows under each class of assets and any dynamic portfolio hedging techniques utilized and the tests performed on the utilization of the techniques. As used in this section, "dynamic portfolio hedging techniques" means techniques whereby an underlying portfolio of liabilities and their corresponding assets are hedged through the purchase or sale (owned or not owned by the hedger) of a hedging instrument, and such purchase or sale is managed so as to decrease the probability or severity of loss of the underlying portfolio due to changes in economic, market, insurable, or other events and the hedge is regularly adjusted or re-balanced through additional purchases or sales of assets, liabilities, or financial instruments (including options, futures, and derivatives) at regular, small intervals as the risks and characteristics of the underlying portfolio change, in a manner that incorporates recent events;

(3) Describe how the valuation actuary reflected the risk of default on obligations and mortgage loans, including obligations and mortgage loans that are not investment grade;

(4) Describe how the valuation actuary has reflected withdrawal risks, if applicable, including a discussion of the positioning of the contracts within the benefit withdrawal priority order pertaining to the contracts;

(5) If the plan of operations provides for investments in separate account or supplemental account assets other than United States government obligations, demonstrate that the rates used to discount contract liabilities accurately reflect expected investment returns (taking into account any foreign exchange risks);

(6) If the contracts provide that in certain circumstances they would cease to be funded by a separate account and instead, would become contracts funded by the general account, clearly describe how any increased reserves would be provided for if and to the extent these circumstances occurred;

(7) State the amount of separate account assets that are not chargeable with liabilities arising out of any other business of the insurance company;

(8) State the amount of reserves and supporting assets as of December 31 and where the reserves and assets are shown in the annual statement;

(9) State the amount of any contingency reserve carried as part of surplus;

(10) For book value contracts, state the market value of supporting assets; and

(11) Where separate account assets are not chargeable with liabilities arising out of any other business of the insurance company, describe how the level of risk charges payable to the general account provider are appropriate compensation for the risk taken by the general account.

(Adopted effective June 1, 2002; amended December 23, 2008)

Sec. 38a-459-18. Asset valuation reserve exemption for certain market value separate accounts

When the insurance company values separate account or supplemental account assets at market value and complies with the asset maintenance requirements pursuant to sections 38a-459-14 to 38a-459-16, inclusive, of the Regulations of Connecticut State Agencies, it need not maintain an asset valuation reserve with respect to these assets.

(Adopted effective June 1, 2002)

Sec. 38a-459-19. Reserve valuation

(a) Reserves for contracts funded by a market value separate account supporting contracts other than index contracts shall be an amount equal to the following:

(1) The total reserve required to be maintained on the valuation date pursuant to section 38a-459-14 of the Regulations of Connecticut State Agencies;

(2) Plus the excess, if any, of the market value of separate account assets (to the extent that the market value of the assets determines the contract holder's benefits, i.e., to the extent the assets are beneficially "client" assets) over the amount determined in accordance with subsection (a)(1) of this section;

(3) Plus any additional amount determined by the valuation actuary as necessary to make adequate provision for all of the contract liabilities;

(4) Plus any additional amount determined as necessary by the insurance commissioner due to the nature of the benefits.

(b) Reserves for index contracts funded by a market value separate account shall be an amount equal to the following:

(1) The total reserve required to be maintained on the valuation date pursuant to section 38a-459-15 of the Regulations of Connecticut State Agencies;

(2) Plus the excess, if any, of the market value of separate account assets (to the extent that the market value of the assets determines the contract holder's benefits,

i.e., to the extent the assets are beneficially “client” assets) over the amount determined in accordance with subsection (b)(1) of this section;

(3) Plus any additional amounts determined by the valuation actuary as necessary to make adequate provision for all of the contract liabilities;

(4) Plus any additional amount determined as necessary by the insurance commissioner due to the nature of the benefits.

(c) Reserves for book value contracts shall be determined as if the contracts were held in the general account.

(d) The amount of any reserves required by subsections (a)(3) and (a)(4) of this section and subsections (b)(3) and (b)(4) of this section may be established by either:

(1) Allocating sufficient assets to the separate account or a supplemental account to satisfy the requirement; or

(2) Setting up the additional reserves in the general account.

(Adopted effective June 1, 2002)

Sec. 38a-459-20. Severability

If any provision of sections 38a-459-10 to 38a-459-20, inclusive, of the Regulations of Connecticut State Agencies or its application to any person or circumstance is 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.

(Adopted effective June 1, 2002)

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Viatical Settlements

Sec. 38a-465-1. Definitions

As used in sections 38a-465-1 to 38a-465-10, inclusive:

- (1) “Commissioner” means the Insurance Commissioner of the State of Connecticut;
- (2) “Insured” means the person covered under a life insurance policy or the holder of a certificate being considered for viatication;
- (3) “Life expectancy” means the average 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 considering medical records and appropriate experiential data;
- (4) “Patient identifying information” means an insured’s address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, social security number or any other information that is likely to lead to identification of the insured;
- (5) “Viatical settlement” means viatical settlement as defined in section 38a-465 of the Connecticut general statutes;
- (6) “Viatical settlement agent” means viatical settlement agent as defined in section 38a-465 of the Connecticut general statutes;
- (7) “Viatical settlement broker” means viatical settlement broker as defined in section 38a-465 of the Connecticut general statutes;
- (8) “Viatical settlement provider” means viatical settlement provider as defined in section 1 of Public Act 99-104;
- (9) “Viator” means viator as defined in section 38a-465 of the Connecticut general statutes.

(Adopted effective November 9, 1998; amended March 1, 2000)

Sec. 38a-465-2. Annual statement reporting requirements

(a) Each viatical settlement provider shall file with the Commissioner on or before March 1 each year, commencing with March 1, 2001, an annual statement containing the following information regarding business transacted in this state for the previous calendar year:

- (1) For each policy viaticated, the date that the viatical settlement was entered into; the life expectancy of the viator at the time of the contract; the face amount of the policy; the amount paid by the viatical settlement provider to viaticate the policy and the percentage that amount represents of the face amount; and if the viator has died, the date, the total insurance premiums paid by the viatical settlement provider to maintain the policy in force and the primary ICD diagnosis code, in numeric format, as defined by the International Classification of Diseases, as published by the U.S. Department of Health and Human Services;
- (2) a breakdown of applications received, accepted, and rejected, by disease category;
- (3) a breakdown of policies viaticated by issuer and policy type;
- (4) the number of secondary market versus primary market transactions;
- (5) the total number of policies viaticated, the total policy premiums paid, the total paid to all viators, and the total commissions paid to viatical settlement brokers;
- (6) the source and amount of outside borrowing or financing; and
- (7) the name and address of each viatical settlement broker through whom the reporting company purchased a policy from a viator who resided in Connecticut at the time of contract.

(Adopted effective November 9, 1998; amended March 1, 2000)

Sec. 38a-465-3. Verification of license status of viatical settlement providers

Each licensed viatical settlement broker shall file on or before March 1 of each year, commencing March 1, 2001, a notarized statement, signed under oath or affirmation, verifying that each viatical settlement provider from which such viatical settlement broker receives a commission or other payment or benefit is licensed in the State of Connecticut.

(Adopted effective November 9, 1998; amended March 1, 2000)

Sec. 38a-465-4. Confidentiality of identity of viator

(a) No person may submit the report required by Section 38a-465-2 in such a manner as would identify any viator except with the express written consent of such viator or the viator's estate or representative;

(b) A viatical settlement agent, viatical settlement broker or viatical settlement provider shall not provide patient identifying information to any person, unless the viator and the insured provide written consent to the release of the information at or before the time of the viatical settlement transaction.

(Adopted effective November 9, 1998; amended March 1, 2000)

Sec. 38a-465-5. Evaluation standards for reasonable payments

(a) A viatical settlement broker, company or provider shall not enter into a viatical settlement that provides payment to the viator that is unreasonable, unjust or inequitable. In determining whether a payment is unreasonable, unjust or inequitable, the commissioner may consider, among other factors, the life expectancy of the viator, the applicable rating of the insurance company that issued the subject policy by a rating service generally recognized by the insurance industry, regulators and consumer groups and the prevailing discount rates in the viatical settlement market in Connecticut, or if sufficient data is unavailable for Connecticut, the prevailing discount rates nationally or in other states that maintain this data; and

(b) A viatical settlement provider shall not use a longer life expectancy than is realistic in order to reduce the payout to which the viator is entitled.

(Adopted effective March 1, 2000)

Sec. 38a-465-6. Amounts payable to viator

(a) Payment of the proceeds of a viatical settlement pursuant to subsection (c) of section 38a-465g of the Connecticut General Statutes shall be made by means of wire transfer to the account of the viator or by certified check or cashier's check.

(b) Payment of the proceeds to the viator pursuant to a viatical settlement shall be made in a lump sum except where the viatical settlement provider has purchased an annuity or similar financial instrument issued by a licensed insurance company or bank, or an affiliate of either. Retention of a portion of the proceeds by the viatical settlement provider or escrow agents is not permissible.

(Adopted effective March 1, 2000)

Sec. 38a-465-7. Prohibited practices

(a) A viatical settlement agent, viatical settlement broker or viatical settlement provider shall not discriminate in the creation or solicitation of a viatical settlement contract on the basis of race, age, sex, national origin, creed, religion, occupation, marital or family status, sexual orientation, or based on whether the viator has children.

(b) A viatical settlement agent, viatical settlement broker or viatical settlement provider shall not pay or offer to pay any finder's fee commission or other compensation to any viator's physician, attorney, accountant, or any other person providing

financial planning services, legal services or medical services to the viator, or to any other person acting as an agent of the viator with respect to the viatical settlement transaction.

(c) A viatical settlement provider shall not knowingly solicit investors who have treated or have been asked to treat the illness of the insured whose coverage would be the subject of the investment.

(d) A viatical settlement provider shall not act also as a viatical settlement broker, whether entitled to collect a fee directly or indirectly, in the same viatical settlement.

(e) A viatical settlement broker shall not, without the written agreement of the viator obtained prior to performing any services in connection with a viatical settlement, seek or obtain any compensation from the viator.

(Adopted effective March 1, 2000)

Sec. 38a-465-8. Advertising practices

(a) Advertising related to the viatical settlement shall be truthful and not misleading by fact or implication.

(b) If the advertiser references 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.

(c) If the advertising references the dollar amounts available to viators, the advertising shall disclose the average purchase price as a percentage of face value obtained by viators contracting with the advertiser during the past six (6) months.

(Adopted effective March 1, 2000)

Sec. 38a-465-9. Interest retained by viator

If a viatical settlement provider enters a viatical settlement that allows the viator to retain an interest in the policy, the viatical settlement contract shall contain the following provisions: (1) 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. Benefits in excess of the amount viaticated shall be paid directly to the viator's beneficiary by the insurance company; (2) a provision that the viatical settlement provider will, upon acknowledgment of the perfection of the transfer, either (A) advise the insured, in writing that the insurance company has confirmed the viator's interest in the policy or (B) send a copy of the instrument sent from the insurance company to the viatical settlement company that acknowledges the viator's interest in the policy; and (3) a provision that apportions the premiums to be paid by the viatical settlement company and the viator. It is permissible for the viatical settlement contract to specify that all premiums shall be paid by the viatical settlement company. The contract may also require that the viator reimburse the viatical settlement provider for the premiums attributable to the retained interest.

(Adopted effective March 1, 2000)

Sec. 38a-465-10. Disclosure requirements

(a) A disclosure document containing the disclosures required in section 38a-465f of the Connecticut General Statutes and sections 38a-465-1 to 38a-465-10, inclusive, of the Regulations of Connecticut State Agencies shall be provided before or concurrent with taking an application for a viatical settlement contract.

(b) The disclosure document shall contain the following language "all medical, financial or personal information solicited or obtained by a viatical settlement company or viatical settlement broker about a viator and an insured, including the

viator and insured's identity of family members, a spouse or a significant other, is confidential.”

(c) The disclosed information required in section 38a-465f of the Connecticut General Statutes and sections 38a-465-1 to 38a-465-10, inclusive, of the Regulations of Connecticut State Agencies shall not be disclosed in any form to any person, unless disclosure: (1) is necessary to effect the viatical settlement; (2) is for an insurer to determine its obligation or responsibility under a policy or certificate and the viator and the insured have provided written consent; or is permitted by law to be disclosed.

(Adopted effective March 1, 2000)

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Submission and Review of Rates for Medicare Supplement Insurance

Sec. 38a-474-1. Definitions

As used in Sections 38a-474-1 to 38a-474-4, inclusive, of the regulations of Connecticut state agencies:

- (1) “Commissioner” means the Insurance Commissioner.
- (2) “Insurer” means insurance company, fraternal benefit society, hospital service corporation, medical service corporation, or health care center.
- (3) “Medicare supplement policy” means any Medicare supplement policy or certificate, as defined in Sections 38a-495, 38a-495a and 38a-522 of the general statutes, delivered, issued for delivery, continued or renewed in this state on or after October 1, 1990 by any insurer.

(Adopted effective November 28, 1995)

Sec. 38a-474-2. Rate submission requirements

(a) Each insurer shall submit the rates on every Medicare supplement policy form for initial approval by the Commissioner and annually thereafter.

(b) An insurer seeking to change rates on a Medicare supplement policy form shall submit the revised rates to the insurance department at least sixty days prior to the proposed effective date of the change. The department shall review the revised rates and, with respect to any request for an increase in rates, shall hold a public hearing on such request in accordance with the department’s rules of practice. The commissioner shall approve or deny any request for a change in rates on a Medicare supplement policy form within forty-five days of its receipt.

(c) Where an insurer does not seek to change rates for a policy form, the insurer shall submit the previously approved rates at least forty-five days before the expiration of twelve months from the effective date of those rates. The commissioner shall either approve the continued use of such rates or notify the insurer that premium adjustments are necessary to achieve the appropriate loss ratio. If the insurer fails to make premium adjustments acceptable to the commissioner, the commissioner shall order premium adjustments, refunds or premium credits necessary to achieve the appropriate loss ratio.

(d) All submission of rates for Medicare supplement policy forms shall be made in duplicate, accompanied by a postage paid return envelope of sufficient size to accommodate the filing. An Actuarial Memorandum describing the basis on which rates were determined shall accompany the submission and shall include the following items:

- (1) The policy form number for which rates are being submitted.
- (2) A cover letter that includes a description of the form in sufficient detail to accurately illustrate its benefits and terms.
- (3) The method of marketing used. A statement that the policy form is actively offered for sale. If a policy has been discontinued, the date when sales ceased shall be stated.
- (4) The rates appropriate for the state, including all modal factors. The assumed period for which the rates are to be effective should be stated.
- (5) The explicit assumptions and factors used in calculating the community rate. These shall include, but are not limited to, any loads for the guaranteed issue requirement, the required offering to the disabled or the automatic crossover system (piggybacking). Experience rating by case is not allowed for group policies.
- (6) A statement of the anticipated loss ratio over the total lifetime of the policy. A demonstration that the minimum loss ratio requirements of 65% for individual

policies and 75% for group policies will be met. Such demonstration shall exclude active life reserves.

(7) The expected future loss ratio projected through the period for which the rates will be effective. An expected third-year loss ratio which is greater than or equal to the applicable loss ratio standard shall be demonstrated for policies or certificates in force less than three years.

(8) A statement signed by a member of the American Academy of Actuaries or another individual acceptable to the commissioner, certifying that: the loss ratios are in compliance with section 38a-495 (b) or section 38a-522 (b) of the general statutes, or section 38a-495a-10 of the regulations of state agencies, as appropriate; the calculations were made in accordance with actuarial standards of practice; the premiums are neither excessive nor inadequate; and the premiums are reasonable in relation to benefits. The address and phone number of the actuary should be stated on the certification.

(9) A demonstration that the rates do not incorporate factors for expenses which exceed one hundred fifty per cent of the average expense ratio for the entire written premium for all of the insurer's lines of health insurance for the previous calendar year in accordance with section 38a-473 of the general statutes. The average expense factor shall be calculated from Schedule H (Accident and Health Exhibit) of the prior year's annual financial statement, as the ratio of A to B where:

A is equal to the Total General Insurance Expenses (excluding taxes, licenses and fees), and

B is equal to the Total Premiums Written.

(10) If the insurer currently sells Medicare supplement policies in this state, a demonstration that the insurer makes at least standardized Plan A available to persons eligible for Medicare by reason of disability. For group filings, a description of the eligibility requirements of the group that includes at a minimum identification of the policyholder, requirements for membership and the purpose of the group.

(11) For forms where underwriting is permitted, a general statement of underwriting limitations.

(12) A table showing amounts proposed to be charged to consumers if the rates are approved as submitted.

(13) Such additional information as the commissioner may deem necessary for an adequate review of the proposed rates.

(e) The Actuarial Memorandum accompanying a submission of revised rates shall include in addition to the information required under subsection (c) the following items:

(1) The policy inforce count and the age/sex distribution both statewide and nationwide for the policy form.

(2) For each policy form, for each calendar year since inception, both statewide and nationwide: incurred claims; earned premium including modal loadings and policy fees; and resulting loss ratios. All claim and premium figures shall reflect actual experience to date.

(3) A history of rate changes for the policy form in Connecticut, including the effective date and magnitude of each previous rate change.

(4) Such additional information as the commissioner may deem necessary for an adequate review of the proposed revised rates.

(Adopted effective November 28, 1995)

Sec. 38a-474-2a. Electronic filing

(a) Any insurer filing rates with the commissioner in accordance with section 38a-474-2 of the Regulations of Connecticut State Agencies may submit such filing

electronically using software known as the System for Electronic Rate and Form Filing (SERFF), Version 2.0 or higher, or any subsequent corresponding system, adopted by the National Association of Insurance Commissioners. All such filings shall include the information required in section 38a-474-2 of the Regulations of Connecticut State Agencies.

(b) Filings made electronically shall be considered received by the commissioner when received at the Insurance Department. Filings received on a weekend or legal holiday shall be deemed received on the next business day. An electronic communication from the Insurance Department concerning a filing shall be deemed received by the person to whom the communication is addressed when the communication is sent to that person.

(Adopted effective January 2, 2002)

Sec. 38a-474-3. Rate review standards

(a) The commissioner shall not approve a rate for a Medicare supplement policy that is excessive, inadequate, unreasonable in relation to the benefits provided or unfairly discriminatory.

(b) Rates for Medicare supplement policy or certificate forms shall not be approved unless the form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders or certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(1) at least seventy-five (75%) of the aggregate amount of premiums earned in the case of group policies, or

(2) 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 care center, and earned premiums for such period and in accordance with accepted actuarial principles and practices. All rate filings shall demonstrate that expected claims in relation to premiums comply with these loss ratio requirements 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 required loss ratio.

(Adopted effective November 28, 1995)

Sec. 38a-474-4. Separability

If any provision of sections 38a-474-1 to 38a-474-3, inclusive, of the regulations of Connecticut state agencies or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

(Adopted effective November 28, 1995)

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Connecticut Partnership for Long Term Care

Sec. 38a-475-1. Applicability and scope

Sections 38a-475-1 to 38a-475-6, inclusive, apply to any long-term care insurance policy or certificate form which the insurance department is requested to precertify in accordance with section 38a-475 of the general statutes.

(Effective October 1, 1991; amended July 30, 1999, January 2, 2008)

Sec. 38a-475-2. Definitions

As used in sections 38a-475-1 to 38a-475-6, inclusive:

(a) “Connecticut Partnership for Long-Term Care” means the program authorized in section 17b-252 of the general statutes.

(b) “Long-Term Care Insurance Policy” means an insurance policy or certificate, the form of which has been approved by the commissioner in accordance with section 38a-481 or section 38a-513 of the general statutes, which meets the requirements of section 38a-501 or section 38a-528 of the general statutes and sections 38a-501-8 to 38a-501-24, inclusive, or sections 38a-528-1 to 38a-528-17, inclusive, of the regulations of Connecticut state agencies.

(c) “Partnership-Approved Policy” or “Precertified Long-Term Care Insurance Policy” or “Precertified Policy” means any long-term care insurance policy that is a qualified long-term care policy as defined in section 7702B(b) of the Internal Revenue Code of 1986 issued for delivery to any resident of this state which is designed to provide, within the terms and conditions of the policy, contract or certificate, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of cognitive or functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for no less than one (1) year at issue after a reasonable elimination period and the form of which is precertified by the insurance department in accordance with section 38a-475 of the general statutes.

(d) “Commissioner” means the insurance commissioner.

(e) “Activities of Daily Living (ADLs)” means each of the following items: dressing, bathing, eating, toileting, continence and transferring. In each instance, an ADL deficiency is determined by reference to the need for substantial human assistance or supervision in performing that activity.

(f) “Mental Status Questionnaire (MSQ)” means the Short Portable questionnaire comprised of 10 questions for clinicians to grade a person’s cognitive status.

(g) “Folstein Mini Mental State Examination” means a method for clinicians to grade a person’s cognitive status.

(h) “Asset Protection” means the right extended by sections 17b-252 and 17b-253 of the general statutes to persons purchasing partnership-approved long-term care insurance policies to retain amounts of assets equal to the sum of qualifying insurance payments made on their behalf in determining eligibility for the Medicaid program.

(i) “Authorized Agent” means a person who has been designated as agent by the insured in writing to the insurance company, or is acting for the insured under a duly executed power of attorney, or is the insured’s duly appointed conservator or guardian.

(j) (1) “Insured Event” means, for purposes of determining asset protection for a privately insured individual, that any one of the following criteria shall have been satisfied:

(A) The individual has a documented need for substantial human assistance, or supervision, with two or more of the following Activities of Daily Living (ADL's): dressing, bathing, eating, toileting, continence and transferring; or

(B) The individual has been assessed using the Mental Status Questionnaire, and has seven or more incorrect responses on the test; or

(C) The individual exhibits specific behavior problems requiring daily supervision, including but not limited to wandering, abusive or assaultive behavior, poor judgment or uncooperativeness which poses a danger to self or others, and extreme or bizarre personal hygiene habits; and has either taken the MSQ and has four or more incorrect responses, or has taken the Folstein Mini Mental State Examination and achieved a score of 23 or lower.

(2) The "Insured Event", for purposes of determining asset protection, shall be the "Insured Event" as defined in the contract.

(3) For purposes of determining eligibility for benefits under a partnership-approved policy, the "insured event" shall use, at a minimum, the following ADLs: dressing, bathing, eating, toileting, continence and transferring and shall be no less restrictive than the "insured event" used for purposes of determining asset protection as defined in subparagraphs (A), (B), (C) of subdivision (1) of this subsection.

(4) The provisions of this subsection shall be used for purposes of determining asset protection, except that federal regulations promulgated under the Health Insurance Portability and Accountability act of 1996 (Public Law 104-191), shall control to the extent that a provision of this subsection is in conflict with said federal regulations.

(k) "Access Agency" means an organization that provides case management services, including assessments and reassessments, care plan development, and coordination and monitoring of home and community-based services and has been approved as an access agency by the Office of Policy and Management and Department of Social Services as meeting the requirements for such agency as defined in section 17b-342 of the general statutes.

(l) "Connecticut Home Care Program for the Elderly of the Department of Social Services" means the program authorized by section 17b-342 of the general statutes.

(m) "Plan of Care" means a written individualized plan of home and community services (including but not limited to "Home and Community-Based Services") which specifies the type and frequency of all services required to maintain the individual at home or in the community, the service providers, and the cost of services, regardless of whether or not there is an actual charge for the service.

(n) "Family Member" means an individual's husband, wife, natural parent, child or sibling, adopted child or parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild.

(o) "Service Summary" means a written summary prepared by an insurer for an individual policyholder which identifies the specific partnership-approved policy, the total benefits paid for services rendered to date and the amount qualifying for asset protection.

(p) "Policyholder" means a certificate holder under a group long-term care insurance policy or a partnership-approved group long-term care insurance policy or the owner of an individual long-term care insurance policy or a partnership-approved individual long-term care insurance policy.

(q) "Home And Community-Based Services" means, at a minimum, the provision of skilled services provided in the home or community such as skilled nursing care, physical, occupational, respiratory and speech therapy; and home health aide services

and support services provided in the home or community which shall include, homemaker, adult day health care and respite care services.

(r) “Uniform Data Set (UDS)” means the reporting requirements for the Connecticut Partnership for Long-Term Care defined in the document “Partnership for Long-Term Care, Long-Term Care Insurance Uniform Data Set Reporting Requirements and Documentation” issued from time to time by the Office of Policy and Management.

(s) “Plan of Action Requirements” means the set of instructions produced and updated by the Office of Policy and Management that insurance companies shall comply with in order to meet the requirements of section 38a-475-5(e) of the regulations of Connecticut state agencies.

(t) “Partnership-Approval” or “Precertification” means the process by which a long-term care policy or certificate form is precertified by the Insurance Department in accordance with section 38a-475 of the general statutes.

(u) “Before You Buy” means a publication produced, and issued from time to time, by the Office of Policy and Management which includes a complete description of the Connecticut Partnership for Long-Term Care.

(Effective October 1, 1991; amended July 30, 1999, January 2, 2008)

Sec. 38a-475-3. Partnership-approval of long-term care policies

No long-term care insurance policy shall be precertified as partnership-approved for purposes of the Connecticut Partnership for Long-Term Care, unless the requirements of sections 38a-475-1 to 38a-475-6, inclusive, of the regulations of Connecticut state agencies are complied with.

(Effective October 1, 1991; amended July 30, 1999, January 2, 2008)

Sec. 38a-475-4. Conditions for partnership-approval

(a) No long-term care insurance policy shall be advertised, solicited, or issued for delivery in this state as a partnership-approved long-term care policy which does not meet the following minimum standards. 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 partnership-approved long-term care policies as defined herein and are in addition to all other requirements of sections 38a-475-1 to 38a-475-6, inclusive, of the regulations of Connecticut state agencies.

(c) Each company seeking partnership-approval for a long-term care insurance product shall:

(1) Notify the Insurance Department in writing that it will provide to the consumer, prior to any application for a partnership-approved policy, a complete description of the Connecticut Partnership for Long-Term Care as prepared by the Office of Policy and Management, including the Connecticut partnership’s toll free phone number, and an outline of coverage.

(2) Offer the option of or include a provision for Home and Community-Based Services, with a minimum benefit of one year at issue, in addition to nursing home care. All home care plans shall include case management services delivered by an access agency. Case management services shall include, but need not be limited to, the development of a comprehensive individualized assessment and plan of care and, as needed, coordination of appropriate services and the monitoring of the delivery of such services.

(3) Provide a provision for inflation protection which satisfies at least one of the following criteria:

(A) The policy covers at least 70 percent of the actual charges or at least 70 percent of the average Connecticut private pay rate, without increases in premium, for that service based on a listing of average private pay rates that will be inflated or updated annually by the Office of Policy and Management and does not include a maximum specified daily indemnity amount or daily limit. The policy shall also provide for increases in lifetime benefit levels, without related increases in premium, at a rate not less than five percent each year over the previous year for each year the contract is in force except that, at the option of the insurer, policyholders and applicants 65 years of age and older may be given the option not to inflate their lifetime benefit levels. Premiums shall be based on the age of the policyholder at the time of the issuance of the partnership-approved policy; or

(B) The policy provides for automatic increases in the per diem dollar level, without related increases in premiums at a rate not less than five percent each year over the previous year for each year the contract is in force. The policy shall also provide for increases in lifetime benefit levels, without related increases in premium, at a rate not less than five percent each year over the previous year for each year the contract is in force except that, at the option of the insurer, policyholders and applicants 65 years of age and older may be given the option not to inflate their lifetime benefit levels. Premiums shall be based on the age of the policyholder at the time of the issuance of the partnership-approved policy.

(4) At a minimum, provide a nursing home benefit of at least \$167.00 a day for policies applied for in 2007. For each year after 2007, the minimum daily nursing home benefit shall be 5% greater than the previous year's minimum, rounded up to the nearest dollar amount. No policy shall pay for care in excess of the actual charges.

In addition, those policies issued with home and community-based services shall provide a daily home and community-based benefit that, at a minimum, equals at least 50 percent of the minimum daily nursing home benefit in effect for any given year. No policy shall pay for care in excess of the actual charges.

Policies that pay benefits based on a percentage of costs, and not a daily benefit amount, shall provide benefits which are equal to at least 70% of the actual charges incurred by the insured or at least 70% of the average private pay rate provided by the Office of Policy and Management for each service.

(5) Use applications to be signed by the applicant acknowledging:

(A) That the agent delivered to the applicant at time of application, a copy of "Before You Buy," the state's toll-free number for consumer assistance, a graphic comparison of inflating vs. fixed benefits and premiums, and a "Notice to Applicants Regarding Mandatory Inflation Protection." The following disclosure statement shall be used (or in substantially similar language).

I acknowledge that I have received a copy of "Before You Buy," a complete description of the Connecticut Partnership for Long-Term Care, prepared by the State of Connecticut, including the state's toll-free number, 1-800-547-3443. I have also been advised that I can request individual consumer information assistance from the State of Connecticut. I have also received a graphic comparison of inflating vs. fixed benefits and premiums and the "Notice To Applicant Regarding Mandatory Inflation Protection."

Signature of Applicant(s)

Date

(B) That the applicant agrees to the release of information by the insurer to the State of Connecticut as may be needed to evaluate the Connecticut Partnership for

Long-Term Care, document a claim for Medicaid asset protection and meet Medicaid audit requirements. said release shall be in the following format and require a separate signature by the applicant(s):

I hereby agree to the release of my insurance records pertaining to this long-term care insurance policy (certificate) by the (insert insurance company name) to the State of Connecticut for the purpose of documenting a claim for Asset Protection under the Connecticut Medicaid program, evaluating the Connecticut Partnership for Long-Term Care, and meeting Medicaid audit requirements. I understand that my records will be used for no purpose other than those stated above, and will be kept strictly confidential by the State of Connecticut.

(Signature of Applicant(s))

Date

(C) That the agent delivered to the applicant at the time of application a description regarding mandatory inflation protection that shall be in the following format:

NOTICE TO APPLICANT REGARDING MANDATORY INFLATION PROTECTION

In order for this long-term care policy (certificate) to remain partnership-approved by the State of Connecticut and qualify to provide Asset Protection for the State Medicaid program in Connecticut, daily coverage benefits shall meet or exceed standards established by the State of Connecticut. The insurance company will provide you with a graphic comparison showing the differences in premiums and benefits, over at least a twenty (20) year period, between a policy that increases benefits and a policy that does not increase benefits. Failure to maintain the required daily coverage benefits will result in the policy losing its partnership-approved status and no longer being allowed to provide Asset Protection. It is the insurance company's responsibility to automatically inflate daily coverage benefit levels in order to maintain partnership-approval; it is your responsibility to make premium payments in order to maintain coverage and eligibility for Asset Protection.

(D) That the agent delivered to the applicant at the time of application a graphic comparison showing the differences in premiums and benefits, over at least a twenty (20) year period, between a policy that increases benefits and a policy that does not increase benefits.

(6) Report all sales involving replacement to the Commissioner within thirty (30) days of the effective date of the newly issued policy or certificate. The report shall include the name and address of the insured, the name of the company whose policy is being replaced and the name of the agent replacing the coverage. For sales involving replacement by an insurer other than a direct response insurer, this report shall also include a comparison of the coverage issued with that being replaced, including a comparison of the premiums and an explanation of how said replacement was beneficial to the insured.

(7) Issue a policy which shall include a provision which allows for a thirty (30) day period within which coverage may be cancelled by the applicant by delivering or mailing the evidence of coverage to the insurer or the agent through whom it was effected for a full refund of any premium that was paid. The policy 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 certificateholder shall have the right to return the policy or certificate to the insurer or its agent for cancellation within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured is not satisfied for any reason.

(8) Agree to provide to each individual who is denied a partnership-approved long term care insurance policy, a survey produced by the Office of Policy and Management which the individual would, at his or her option, complete and return to the Office of Policy and Management.

(9) Issue a policy which does not require prior hospitalization or a prior stay in a nursing home as a condition of providing benefits.

(10) Provide assurances to the Commissioner that no agent will be authorized to market, sell, solicit or otherwise contact any person for the purpose of marketing a partnership-approved long-term care insurance policy unless the agent has completed, seven hours of training on long term care insurance in general and the Connecticut Partnership for Long-Term Care specifically. Such assurances shall be in the form of a document signed by [the agent and] a representative of the company attesting to the completion of the required training by the agent and submitted to the Commissioner. All training programs designed to meet the requirements of this subdivision shall receive prior approval from the Office of Policy and Management.

(11) Issue a policy which, in the event the policy is about to lapse, proactively offers, as defined in this subdivision, the insured the option to switch their coverage to a lower lifetime maximum benefit. The offering shall provide the policyholder the option of reducing their lifetime maximum benefit to any lifetime maximum benefit available from the insurer. The offering shall include, at a minimum, an option covering a period of care less than or equal to two years. After the policy has been in force for at least one (1) year, this option need only be offered one time. Premiums shall be based on the age of the policyholder at the time of the issuance of the original partnership-approved policy and shall be less than the premium the policyholder had been charged prior to electing the lower lifetime maximum benefit. Except for the premium and lifetime maximum benefit, all other provisions and benefits that were part of the policy at the time the lifetime maximum benefit was changed shall remain in force. For purposes of this subdivision, proactively offering the lower lifetime maximum benefit means, at a minimum, sending a letter to the policyholder explaining the option to switch coverage to a lower amount, while providing no less than 15 days for the policyholder to switch their coverage before their policy lapses, except in a case where:

(A) The balance of the original policy's available benefits (after any claims have been paid) would provide for the equivalent of one year of coverage or less; or

(B) The original policy was issued with the equivalent of one year of coverage.

(12) Issue a policy which in the event a policyholder lapses a partnership-approved policy and retains a non-forfeiture benefit, the policy will maintain its partnership-approval status only so long as the partnership-approved policy's non-forfeiture benefit will pay benefits. A non-forfeiture benefit that returns premium to the policyholder will result in the policy losing its partnership-approval once the return of premium non-forfeiture benefit is accessed.

(13) Issue a policy which defines "One period of confinement" as meaning consecutive days of confinement: it shall be deemed to include successive periods of confinement which are due to the same or related cause and are not separated by at least ninety (90) days during which the insured is not confined for either skilled nursing care, custodial, intermediate care, or home and community-based care.

(14) Issue a policy that makes maximum benefits available in dollars and not in days of care. Nothing in this subsection shall prevent an insurance company from expressing its maximum benefits as days of care when marketing their partnership-approved policies as long as the actual payment of benefits is based on dollars and not days of care.

(15) Issue a policy that provides for one pool of benefit dollars when home and community-based services are chosen in addition to nursing home benefits. The one pool of benefit dollars will be available to the insured to cover any of the benefits covered under the policy.

(16) Issue a policy that does not limit payments to the room and board charges in an institution, such as a nursing home, as long as the payments do not exceed the daily maximum benefit or the actual charges.

(17) Issue a policy that includes a description of Medicaid asset protection and Connecticut Partnership for Long-Term Care residency requirements in the policy and outline of coverage. The plan of action requirements will include the format and language to be used for the description.

(18) Issue a policy that includes licensed homemaker-home health aide agencies as an eligible provider in the policy and certificate.

(d) Long-term care insurance policies that qualify for partnership-approval will be required to include a statement on the front page of the policy and on the outline of coverage in bold type and in contrasting color to the effect that the policy has been partnership-approved and provides Medicaid asset protection under the Connecticut Partnership for Long-Term Care. Long-term care insurance policies that qualify for partnership-approval shall utilize the Connecticut Partnership for Long-Term Care logo on partnership-approved policies, outlines of coverage and applications in a manner prescribed by the Office of Policy and Management. Conversely, long-term care insurance policies that are not partnership-approved shall include a statement on the front page of the policy in bold type and in contrasting color to the effect that the policy does not qualify for Medicaid asset protection. Such statement shall be as follows: "This Policy Does Not Qualify For Medicaid Asset Protection."

(e) Long-term care insurance policies in force at the effective date of this regulation may be amended to qualify for partnership-approval by fulfilling all partnership-approval requirements.

(Effective October 1, 1991; amended July 30, 1999, January 2, 2008)

Sec. 38a-475-5. Insurer documentation and reporting

Unless otherwise noted, the requirements of subsections (a) to (f), inclusive, of this section refer to insurer documentation and reporting requirements for partnership-approved policies.

(a) Each insurer in fulfilling its reporting requirements shall adhere to the most recent specifications set forth in the Partnership For Long-Term Care Long-Term Care Insurance Uniform Data Set (UDS) and Connecticut state-specific requirements as noted in the Connecticut Partnership for Long-Term Care section of the state specific appendices of the UDS documentation. All reports are due to the Office of Policy and Management no later than thirty (30) days after the close of the reporting periods specified for the respective reports.

(b) **Maintaining Auditing Information.** Each insurer shall maintain information as stipulated in subdivisions (1), (2) and (3) of this subsection, on all policyholders who have ever received any benefit under the policy. Such information shall be updated at least quarterly; but this requirement for updating shall not require the conduct of any assessment, reassessment, or other evaluation of the policyholder's condition which is not otherwise required by federal or state statute or regulation. When a policyholder who has received any benefit dies or lapses his policy for any other reason the insurer shall retain the stipulated information for at least five years after the time when the policy ceases to be in force. At the time the policy ceases

to be in force, the insurer shall notify the policyholder of their right to request their service records as stipulated in subdivisions (1), (2) and (3) of this subsection. The insurer shall also, upon request, provide such policyholder and the policyholder's authorized agent, if any, with a complete copy of the insurer's service records as stipulated in subdivisions (1), (2) and (3) of this subsection. These records shall be provided to the policyholder and policyholder's authorized agent, if any, within sixty days of the request. The insurer shall enclose with the records a statement advising the former policyholder that it is in his or her interests to retain the records if he or she may ever wish to establish eligibility for Medicaid.

The information includes:

(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 access agency staff, as part of the initial assessment of the client or as part of a subsequent reassessment.

(B) By an assessment conducted by the Connecticut Home Care Program for the Elderly of the Department of Social Services;

(C) By an assessment of a resident of a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) as required by section 1919 (b)(3) of the Social Security Act;

(D) 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 subparagraphs (a), (b) and (c) of this subdivision. Assessments described in this subparagraph are valid only for persons for whom evidence was not available or not provided in a manner described in subparagraphs (a), (b) or (c) of this subdivision. These assessments shall 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 shall 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:

(A) Name, address, phone number and license number (if applicable) of provider(s);

(B) Amount, date and nature of services provided indicating under which category, if any, the service qualifies for asset protection;

(C) Dollar amounts paid by the insurers, 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 access agency (if applicable) and copies of all assessments and reassessments.

(3) In order for home and community-based services to qualify for asset protection, they shall be in accord with a plan of care approved by an access agency. If the policyholder has received any benefits delivered as part of a plan of care, the insurer shall retain the following:

(A) A copy of the original plan of care;

(B) Copies of any reviews of the plan of care;

(C) Copies of any changes made in the plan of care. The plan of care shall 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 access agency adds the documented need for and description of the new services to the plan of care. In cases

when the service begins 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 business days of the commencement of the new services. Insurers shall maintain initial assessments and subsequent reassessments as part of insured event documentation.

(c) **Reporting on Asset Protection.** Each insurer shall send an asset protection report at least quarterly to each policyholder who has received any benefits since the last asset protection report sent to the policyholder. Each asset protection report shall include the following information:

(1) The amount of asset protection for which the policyholder had qualified prior to the quarter covered by the report.

(2) The total benefits paid by the insurer for services rendered during the quarter.

(3) A statement of the amount of benefits paid by the insurer for services rendered during the quarter which qualify for asset protection.

(4) A summary total of the amount paid to date under the policy which qualifies for asset protection.

(A) The format and wording for the asset protection report shall be described in the Plan of Action Requirements provided by the Office of Policy and Management.

(B) Copies of all asset protection reports shall also be sent to the Office of Policy and Management on a quarterly basis.

(C) Asset protection reports shall be subject to audit by the Department of Social Services under the same requirements as specified in subsection (e)(2) of this section which covers the records in subsection (b) of this section.

(d) **Preparing A Service Summary.** Each insurer shall prepare a service summary at the client's request specifically for the purpose of the policyholder applying for Medicaid. Also the insurer shall prepare a service summary when the policyholder has exhausted his/her benefits under the policy or when the policy ceases to be in force for a reason other than the death of the policyholder, whichever occurs first. The service summary shall identify the specific partnership-approved policy, the total benefits paid for services rendered to date, and the amount qualifying for asset protection. This Service Summary is separate and in addition to the information requirement described above in subsection (b) of this section. The format and wording for the service summary report shall be described in the Plan of Action Requirements provided by the Office of Policy and Management. Copies of all service summary reports shall also be sent to the Office of Policy and Management on a quarterly basis.

(e) **Submitting Plan of Action.** Each insurer shall, prior to partnership-approval by the commissioner, submit to the Office of Policy and Management a plan for complying with the information maintenance and documentation requirements set forth in this section. No policy shall be partnership-approved until the Office of Policy and Management has approved the insurer's documentation plan for the policy. When the Office of Policy and Management determines that a plan of action is adequate, they shall advise the Commissioner and the insurer of that fact in writing. If the Office of Policy and Management determines that there are shortcomings in a plan of action, they shall advise the Commissioner and the insurer of those shortcomings in writing and shall cooperate with the insurer in efforts to resolve them. The documentation plan shall include, but need not be limited to, the following:

(1) The location where records will be kept. Records required for purposes of the Connecticut Partnership for Long-Term Care shall be available at one location,

which is easily available to staff of the Department of Social Services and the Insurance Department.

(2) The insurer shall agree to give the Department of Social Services access to all information, described in subsection (b) of this section, Maintaining Auditing Information, on an aggregate basis for all policyholders and on an individual basis for all policyholders who have ever received any benefits. Access to information on persons who have not applied for Medicaid is required in order for Department of Social Services to determine if an insurer's system for documenting asset protection is functioning correctly. Department of Social Services shall have the final decision concerning the frequency of access to the data and the size of samples for auditing or other purposes. The insurer shall be responsible for any reasonable expenses associated with any audit of its Connecticut Partnership for Long-Term Care records or systems that occurs outside of the state of Connecticut.

(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 the Office of Policy and Management, and the Department of Social Services, concerning the information.

(4) Methods for determining when insurance benefits qualify for asset protection, including documentation of the insured event, description of services, documentation of charges and benefits paid, and documentation of plans of care when required.

(5) Description of manual and electronic systems which will be used in maintaining the required information.

(6) Information which will be retained which is needed to comply with these regulations.

(7) Forms and descriptions of standard procedures for maintaining and reporting the information required. In the event that all or part of the data will be provided in computer-readable form, the specific medium (i.e., tape, diskette, etc.) shall be specified in addition to a description of the relevant file(s).

(8) The asset protection statement to be used in the policy, certificate when used, and outline of coverage. Format for the asset protection statement is included in the Plan of Action Requirements.

(9) A participation agreement with the Office of Policy and Management to be signed by an officer of the insurer. The participation agreement is included in the Plan of Action Requirements provided by the Office of Policy and Management. The participation agreement shall include, but need not be limited to:

(A) A statement that the insurer agrees to make a good faith effort to make revisions and upgrades to their partnership-approved policies and certificates by no later than the time they make revisions and upgrades to their policies and certificates available in Connecticut that are not partnership-approved; and

(B) A statement that the insurer will provide to the Office of Policy and Management a toll-free phone number that the public can utilize to obtain information regarding the insurer's partnership-approved policies and certificates. Such toll-free phone number shall be staffed with personnel familiar with the insurer's partnership-approved policies and certificates.

(10) Forms filed with the Commissioner for partnership-approval, including, but not limited to, policy forms, outlines of coverage, applications, riders, and endorsements.

(f) Auditing and Correcting Deficiencies In Insurer Record-Keeping. The following represent instances of insurer deficiency, procedures for resolution, asset protection determinations and required penalties:

(1) Within one year of the first time that any policyholder of a particular company's policy has met the criteria for the insured event, and as often as Department of Social Services deems necessary thereafter, Department of Social Services shall conduct a systems audit of that company's records. The insurer shall be responsible for advising Department of Social Services when this one year period has begun. Department of Social Services shall promptly inform each insurer of inaccuracies and other potential problems discovered in its systems audits, and shall cooperate with insurers in efforts to correct any problems in the insurer's methods of operation. It is the responsibility of the insurer to make any necessary corrections.

(2) Department of Social Services shall periodically audit a sample of individual applications to Medicaid of persons who have qualified for asset protection. Department of Social Services shall have the final decision concerning sample sizes and other auditing methods. Department of Social Services shall promptly advise insurers of any problems discovered, and shall cooperate with insurers in efforts to correct any problems in the insurer's methods of operation. Department of Social Services shall also notify the insurer of any obligations described in this subsection to hold clients harmless.

(3) The Commissioner of Social Services may enter into voluntary arrangements with insurers of partnership-approved long-term care insurance policies under which the Commissioner of Social Services, or his designee, would issue binding determinations as to whether or not services qualify for asset protection. Policyholders may submit requests for information and advice through their insurer or access agency. When the procedures described in this subdivision are followed in all material respects, the written determinations of the Commissioner of Social Services or his designee concerning whether services qualify for asset protection shall be binding upon the Department of Social Services in all subsequent actions, and the Department of Social Services shall not make any assertion contradicting these determinations in any action arising in this subsection:

(A) All requests for determinations as to whether or not services qualify for asset protection shall be submitted to the Commissioner of Social Services or his designee in writing. These requests may include but are not limited to requests for determinations in the following areas:

- (i) Whether the insured event has occurred and has been adequately documented;
- (ii) Whether a plan of care is required;
- (iii) Whether a revision of a plan of care is required;
- (iv) Whether a service or services is in accord with the Plan of Care;
- (v) Whether a service is of such a nature as to qualify for asset protection as defined in Department of Social Services' Uniform Policy Manual;
- (vi) Whether the applicable amount is the amount paid by the insurer or the amount charged for the service;
- (vii) Whether a provider or proposed provider of service(s) is a "family member" as defined in Department of Social Services' Uniform Policy Manual.

(B) The Commissioner of Social Services or his designee may require insurers and access agencies submitting requests for determinations to provide all records and other information necessary for making a determination. These may include, but not necessarily be limited to, assessments, plans of care, and 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 later determined to be materially inaccurate, the determination based on the inaccurate information shall not be binding on Department of Social Services in subsequent actions. In the case

of a policyholder for whom a determination has been invalidated because information provided was determined to be inaccurate, the provisions of this subsection will apply in the same manner as for any other policyholder.

(C) The Commissioner of Social Services or his designee shall render a determination on each request in writing. Each determination of the Commissioner of Social Services or his designee shall state the reason(s) for the determination, including the relevant facts, documentation of facts, statutes, regulations, and policies.

(D) A copy of all determinations of the Commissioner of Social Services or his designee shall be kept on file at Department of Social Services, together with the related records and information. The original of the determination shall be sent to the insurer or the access agency who originally requested it. The recipient of the original determination shall be responsible for notifying the policyholder or policyholder's authorized agent.

(4) When an audit or other review by the Department of Social Services reveals deficiencies in the record keeping procedures of an insurer, Department of Social Services shall notify the insurer of the deficiencies, and establish a reasonable deadline for correction. If an insurer fails to correct deficiencies within a reasonable period of time, the Department of Social Services shall notify the Commissioner of the deficiencies.

(5) The Commissioner reserves the right to remove partnership-approval status of a long-term care insurance policy on account of an insurer's failure to comply with any of the provisions of sections 38a-475-1 to 38a-475-6, inclusive, of the regulations of Connecticut state agencies. If the Commissioner removes partnership-approval status from a long-term care insurance policy, policyholders who purchased their policies while the policy was partnership-approved will retain their right to asset protection. Policyholders who purchase their policies after the removal of partnership-approval status will have no right to asset protection.

When a policy's partnership-approval status is removed, or an insurer discontinues selling a partnership-approved policy, the insurer shall continue to comply with the documentation and reporting requirements in this section regarding policies already issued. In the event an insurer enters into an assumption agreement covering partnership-approved policies, the insurer shall obtain an undertaking from the assuming insurer that it will continue to comply with the documentation and reporting requirements applicable to the assumed policies.

(6) If an insurer prepares a Service Summary or Asset Protection Report which is used in a Medicaid application for a policyholder, and the client is found eligible for Medicaid, and the policyholder after receiving Medicaid services is found to be ineligible for Medicaid solely by reason of errors in the insurer's Service Summary, Asset Protection Report or documentation of services, the Department of Social Services may require the insurer to pay for services counting towards asset protection required by the policyholder until the insurer has paid an amount equal to the amount of the insurer's errors; after which the policyholder, if otherwise eligible, shall qualify for Medicaid coverage.

(7) If the Department of Social Services determines that an insurer's records pertaining to a policyholder who has received Medicaid benefits are in such condition that the Department of Social Services cannot determine whether the policyholder qualifies for asset protection, the Department of Social Services may require the insurer to pay for services counting towards asset protection required by the policyholder until the insurer has paid an amount equal to the amount of the insurers errors; after which the policyholder, if otherwise eligible, shall qualify for Medicaid coverage.

Compliance with subparagraphs (6) and (7) above, is a requirement for a policy to retain partnership-approval.

(Effective October 1, 1991; amended July 30, 1999, January 2, 2008)

Sec. 38a-475-6. Separability

If any provision of sections 38a-475-1 to 38a-475-6, inclusive, or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of these regulations and the application of such provision to other persons or circumstances shall not be affected thereby.

(Effective October 1, 1991; amended July 30, 1999, January 2, 2008)

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Repealed 38a-478m-1

Notice to Enrollees

Sec. 38a-478m-1.

Repealed, September 4, 2012.

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External Appeals

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Repealed, September 4, 2012.

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Managed Care

Sec. 38a-478u-1. Applicability and scope

Nothing in Sections 38a-478u-1 to 38a-478u-7, inclusive, shall be construed to apply to the arrangements of managed care organizations offered to individuals covered under self-insured employee welfare benefit plans established pursuant to the federal Employee Retirement Income Security Act of 1974, or to any plan providing health care solely for workers' compensation benefits.

(Adopted effective April 5, 1999; amended August 30, 2004)

Sec. 38a-478u-2. Definitions

As used in sections 38a-478u-1 to 38a-478u-7, inclusive, of the Regulations of Connecticut State Agencies:

- (1) "Commissioner means the Insurance Commissioner;
- (2) "Enrollee" means a person who has contracted for or who participates in a managed care plan for himself or his eligible dependents who participate in a managed care plan;
- (3) "Managed care organization" means "managed care organization" as defined in section 38a-478(2) of the Connecticut General Statutes;
- (4) "Managed care plan" means "managed care plan" as defined in section 38a-478(3) of the Connecticut General Statutes;
- (5) "Provider" means "provider" as defined in section 38a-478(4) of the Connecticut General Statutes; and
- (6) "Utilization review" means "utilization review" as defined in section 38a-226 of the Connecticut General Statutes.

(Adopted effective April 5, 1999; amended August 30, 2004)

Sec. 38a-478u-3. Annual filing requirements

Each managed care organization shall file annually the information specified below.

(1) Quality Assurance Reports

(A) A summary report on its quality assurance plan inclusive of, but not limited to, information on complaints relating to providers and quality of care, decisions related to patient requests for coverage and prior authorization statistics. All information provided shall be as of the prior calendar year and shall pertain to Connecticut business only. In order for the statistical information to be provided in a manner permitting comparison across plans, each managed care organization shall be required to complete a form provided by the Insurance Department.

(B) Where Health Plan Employer Data and Information Set (HEDIS) data is required for the summary report, managed care organizations who do not provide HEDIS information to the National Committee for Quality Assurance shall have provided equivalent data upon submission of a completed consumer report card survey as required by subsection (2).

(2) Consumer Report Card

A survey based on prior calendar year information to be submitted on a form adopted by the commissioner.

(3) Model Provider Contracts

Model provider contracts that contain the provisions currently in force in the contracts with providers who participate in networks utilized in this state by the managed care organizations. In a case where a managed care organization does not contract directly with providers, the managed care organization shall also provide

written assurance that it will not enter into agreements with networks or other entities whose provider contracts violate any of the provisions of Public Act 97-99. If requested by the commissioner, a copy of any signed individual contract shall be filed but proprietary fee schedule information may be withheld or redacted.

(4) Financial Arrangements

A written description of the types of financial arrangements between the managed care organization and hospitals, utilization review companies, physicians and other entities that provide health care services or supplies to enrollees. "Financial arrangements" means the terms which are the basis for compensation for services and supplies provided to enrollees.

(Adopted effective April 5, 1999)

Sec. 38a-478u-4. Notification of primary care physician termination

Each managed care organization shall send written notice to each affected enrollee at his last known address no later than thirty days after sending or receiving notice of termination or withdrawal of a primary care physician from its network.

(Adopted effective April 5, 1999)

Sec. 38a-478u-5. Medical loss ratio

For the purposes of reporting and disclosure in accordance with Sections 4 and 8 of Public Act 97-99 as amended by Public Act 97-8, June 18 Special Session, "medical loss ratio" means the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss, reinsurance, enrollee educational programs or other cost containment programs or features.

(Adopted effective April 5, 1999)

Sec. 38a-478u-6. Prior certification

Each managed care plan that requires preauthorization procedures may require enrollees to obtain prior certification or preauthorization for covered services provided (1) such services are clearly identified in the policy or certificate, and (2) the maximum penalty assessed to the enrollee if the enrollee fails to obtain the required prior certification or preauthorization for services ultimately determined to be medically necessary is limited to the lesser of five hundred dollars or fifty percent of the scheduled benefit in the policy or certificate.

(Adopted effective August 30, 2004)

Sec. 38a-478u-7. Separability

If any provision of sections 38a-478u-1 to 38a-478u-7, inclusive, of the Regulations of Connecticut State Agencies or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the provisions of sections 38a-478u-1 to 38a-478u-7, inclusive, of the Regulations of Connecticut State Agencies, and the application of such provision to other persons or circumstances shall not be affected thereby.

(Adopted effective April 5, 1999; renumbered from § 38a-478u-6 and amended August 30, 2004)

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Requirements for Pharmacy Benefits Managers Applying for a Certificate of Registration to do Business in the State of Connecticut

Sec. 38a-479aaa-1. Definitions

As used in section 38a-479aaa-1 to Section 38a-479aaa-5, inclusive, of the Regulations of Connecticut State Agencies:

- (1) "Commissioner" means the Insurance Commissioner;
- (2) "Material modification" means a change in the information provided under section 38a-479aaa-3(a)(1)(A) through (G), inclusive, and under section 38a-479aaa-3(a)(2)(D) of the Regulations of Connecticut State Agencies;
- (3) "Person" means person, as defined in section 38a-1 of the general statutes;
- (4) "Pharmacy benefits manager" means a person as defined in section 38a-479aaa of the Connecticut General Statutes.

(Adopted effective April 7, 2009)

Sec. 38a-479aaa-2. Timing of application and registration

(a) Each person acting as a pharmacy benefits manager on January 1, 2008 shall obtain a certificate of registration from the commissioner on or before April 1, 2008, after completion of an application form containing the information described in section 38a-479aaa-3 of the Regulations of Connecticut State Agencies and approval of the application by the commissioner. All certificates of registration shall expire annually on December 31st of each year. A pharmacy benefits manager that continues to do business in the State after January 1, 2008 shall renew its certificate of registration annually and submit a renewal application to the commissioner by November first annually for a January first effective date of renewal of the certificate of registration.

(b) A person seeking to commence activity as a pharmacy benefits manager in the state after January 1, 2008, shall first apply for, and receive, a certificate of registration from the commissioner as a pharmacy benefits manager, before commencing such activity. Upon receipt of a certificate of registration, such person may perform the business of a pharmacy benefits manager from the effective date of the certificate of registration through December 31 of that year. Thereafter, the pharmacy benefits manager shall renew its certificate of registration on an annual basis as set forth in subsection (a) of this section.

(Adopted effective April 7, 2009)

Sec. 38a-479aaa-3. Contents of application

(a) The filing required from a pharmacy benefits manager shall include the following information:

(1) The identity of the pharmacy benefits manager and any company or organization controlling the operation of the pharmacy benefits manager, including the name, business address, and contact person, for the pharmacy benefits manager and the controlling entity, and, where applicable, the following:

(A) a certificate from the Secretary of the State regarding the pharmacy benefits manager's and the controlling company's or organization's, if applicable, good standing to do business in the state;

(B) the name, address, official position and professional qualifications of each individual responsible for the conduct of the affairs of the pharmacy benefits manager, including all members of the board of directors, board of trustees, executive committee, other governing board or committee, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association,

and any other person who exercises control or influence over the affairs of the pharmacy benefits manager;

(C) the name, address, official position and professional qualifications of each individual who is a member of the controlling company's or organization's board of directors or other policy-making body and of those executive officers who are responsible for the controlling company's or organization's activities with respect to the pharmacy benefits services;

(D) a list of the pharmacy benefits manager's principal owners;

(E) in the case of an out-of-state pharmacy benefit manager, controlling company or organization, a certificate that such pharmacy benefits manager, company, or organization is in good standing in its state of organization;

(F) a report of the details of any suspension, sanction or other disciplinary action relating to the pharmacy benefits manager, or controlling company or organization, in this state or in any other state; and

(G) the name and address of the agent for service of process for the pharmacy benefits manager in the state.

(2) A general description of the pharmacy benefits manager, including:

(A) the geographical service area of the pharmacy benefits manager;

(B) a list of all entities on whose behalf the pharmacy benefits manager has contracts or agreements to provide pharmacy benefits services to state residents;

(C) an approximate number of total enrollees served under all of the pharmacy benefits manager's contracts or agreements in the state and nationwide; and

(D) a contingency plan describing how contracted pharmacy benefits services will be provided in the event of insolvency of the pharmacy benefits manager.

(3) Financial information concerning the pharmacy benefits manager, including:

(A) the most recently concluded fiscal year-end financial statements for the pharmacy benefits manager and its controlling company or organization, which statements have been audited by an independent certified public accountant (CPA) under U.S. generally accepted accounting principles (GAAP);

(B) the names and addresses of the public accounting firm and internal accountant(s) preparing or assisting in the preparation of such financial statements; and

(C) evidence of a surety bond in the amount required pursuant to section 38a-479bbb of the Connecticut General Statutes.

(4) A certification signed by the Chief Executive Officer of the pharmacy benefits manager attesting to the accuracy of the information contained in the filing.

(b) In the event of a material modification to the information provided by the pharmacy benefits manager in its application for a certificate of registration, the pharmacy benefits manager shall file information on the material modification with the commissioner, including supporting documentation, not later than 30 days after such modification.

(Adopted effective April 7, 2009)

Sec. 38a-479aaa-4. Contents of exemption form

A pharmacy benefits manager seeking exemption from registration pursuant to section 38a-479bbb of the Connecticut General Statutes shall notify the commissioner and include the following information in the notification:

(1) the name and address of the pharmacy benefits manager, including the name, address, phone number, and email address of a contact person at the pharmacy benefits manager;

(2) the name and address of the health insurer, health care center, hospital service corporation, medical service corporation, or fraternal benefit society for which entity

the pharmacy benefits manager is operating as a line of business or is an affiliate, and the name, address, phone number, and email address of a contact person at such entity; and

(3) certification by the Chief Executive Officer of the health insurer, health care center, hospital service corporation, medical service corporation, or fraternal benefit society that the pharmacy benefits manager is operating as a line of business under, or affiliate or subsidiary of, such entity.

(Adopted effective April 7, 2009)

Sec. 38a-479aaa-5. Timing of exemption request

(a) For pharmacy benefits managers doing business on January 1, 2008, as set forth in subsection (d) of section 38a-479bbb of the Connecticut General Statutes, the health insurer, health care center, hospital service corporation, medical service corporation, or fraternal benefit society shall make the filing described in section 38a-479aaa-4 of the Regulations of Connecticut State Agencies before April 1, 2008, and thereafter prior to January 1 of each subsequent year, for so long as the pharmacy benefits manager continues to do business in the state, and for so long as the pharmacy benefits manager remains a line of business of, or affiliate or subsidiary of, the entity filing for exemption.

(b) For pharmacy benefits managers commencing business after January 1, 2008, the entity claiming exemption shall file an exemption form as set forth in section 38a-479aaa-4 of the Regulations of Connecticut State Agencies before commencing business in the state, and thereafter prior to January 1st of each subsequent year, under the circumstances set forth in subsection (a) of this section.

(Adopted effective April 7, 2009)

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Coordination of Benefits

Sec. 38a-480-1. Purpose and scope

(a) **Purpose.** The purpose of this regulation is to adopt a group coordination of benefits regulation. This regulation is intended to establish uniformity in the permissive use of overinsurance provisions and to avoid claim delays and misunderstandings that could otherwise result from the use of inconsistent or incompatible provisions among plans.

(b) **Coordination of Benefits.** A Coordination of Benefits (COB) provision is one that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more Plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which Plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It avoids duplication of benefits by permitting a reduction of the benefits of a Plan when, by the rules established by this regulation, it does not have to pay its benefits first.

(Effective September 25, 1992)

Sec. 38a-480-2. Applicability

(a) **Coordination Permissive.** This regulation permits, but does not require, Plans to include COB provisions.

(b) **Consistency with this Regulation.** If a group contract includes a COB provision, it must be consistent with this regulation. A Plan that does not include such a provision may not take the benefits of another Plan as defined in Section 38a-480-3 Definitions into account when it determines its benefits. There is one exception: a contract holder's coverage that 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.

(Effective September 25, 1992)

Sec. 38a-480-3. Definitions

(a) **Plan.**

(1) A "Plan" is 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 COB provision of that contract. The right to include a type of coverage is limited by the rest of this subsection 38a-480-3 (a).

(2) The definition shown in the COB Provision in Section 38a-480-4 is an example of what may be used. Any definition that satisfies this subsection 38a-480-3 (a) may be used.

(3) This regulation uses the term "Plan." However, a group contract may, instead, use "Program" or some other term.

(4) "Plan" shall not include individual or family:

(A) insurance contracts;

(B) subscriber contracts;

(C) coverage through Health Maintenance Organizations (HMOs); or

(D) coverage under other prepayment, group practice and individual practice plan; except as provided in (5) and (6) below.

(5) "Plan" may include:

(A) group insurance and group subscriber contracts;

(B) uninsured arrangements of group or group-type coverage;

(C) group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; and

(D) group-type contracts.

Group type contracts are contracts which are not available to the general public and 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 its 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"). The use of payroll deductions by the employee, subscriber or member to pay for the coverage is not sufficient, of itself, to make an individual contract part of a group-type plan.

(6) "Plan" may include the medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts.

(7) "Plan" may include Medicare or other governmental benefits. That part of the definition of "Plan" may be limited to the hospital, medical and surgical benefits of the governmental program. However, "Plan" shall not include a state plan under Medicaid, and shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.

(8) "Plan":

(A) shall not be construed to include group or group-type hospital indemnity benefits of \$30 per day or less; but

(B) may be construed to include the amount by which group or group-type hospital indemnity benefits exceed \$30 per day.

"Hospital indemnity benefits" are those 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.

(9) "Plan" shall not include student accident or student accident and health coverages for which the student or parent pays the entire premium.

(10) "Plan" shall not include:

(A) group contracts issued by or reinsured through the Health Reinsurance Association; or

(B) subscriber contracts issued by a residual market mechanism established by hospital and medical service corporations and providing comprehensive health care coverage as provided in Chapter 700a of Connecticut General Statutes.

(b) **This Plan.** In a COB provision, this term refers to the part of the group contract providing the health care benefits to which the COB provision applies and which may be reduced on account 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 COB provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

(c) **Primary Plan.** A Primary Plan is one 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 (1) or (2) below is true:

(1) The Plan either has no order of benefit determination rules, or it has rules which differ from those permitted by this regulation.

(2) All plans which cover the person use the order of benefit determination rules required by this regulation and under those rules the Plan determines its benefits

first. There may be more than one Primary Plan (for example, two Plans which have no order of benefit determination rules).

(d) **Secondary Plan.** A Secondary Plan is one which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this regulation 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 the rules of this regulation, has its benefits determined before those of that Secondary Plan.

(e) **Allowable Expense.**

(1) "Allowable Expense" is 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. However, 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.

(2) When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

(3) The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

(4) When COB is restricted in its use to a 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 COB applies.

(f) **Claim.** A request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of:

- (1) services (including supplies);
- (2) payment for all or a portion of the expenses incurred;
- (3) a combination of (1) and (2) above; or
- (4) an indemnification.

(g) **Claim Determination Period.**

(1) This is the period of time, which must be not less than twelve consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine:

- (A) whether overinsurance exists; and
- (B) how much each Plan will pay or provide.

It usually is 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 that Claim Determination Period.

(2) 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; but that determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

(Effective September 25, 1992)

Sec. 38a-480-4. COB contract provision

(a) **General.** Subsection 38a-480-4 (d) contains a COB Provision for use in group contracts. That use is subject to the provision of subsections 38a-480-4 (b) and 38a-480-4 (c) and to the provisions of Section 38a-480-3, Definitions, and Section 38a-480-5, Rules for Coordination of Benefits. The bracketed references in the COB Provision to those rules are not to be included in a group contract.

(b) **Flexibility.** A group contract's COB provision does not have to use the words and format shown in this regulation. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among Plans:

- (1) which provides services;
- (2) which pay benefits for expenses incurred; and
- (3) which indemnify.

Substantive changes are allowed only as set forth in this regulation.

(c) **Prohibited Coordination and Benefit Design.** A group contract may not reduce benefits on the basis that:

- (1) another plan exists;
- (2) except with respect to Part B of Medicare, a person is or could have been covered under another Plan; 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.

No contract may contain a provision that its benefits are "excess" or "always secondary" to any Plan defined in subsection 38a-480-3 (a), except in accord with the rules permitted by this regulation.

(Reference: Rules in subsection 38a-480-5 (a) (1) below.)

(d) **Text of the COB Provision.**

COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

(1) Applicability.

(A) This Coordination of Benefits ("COB") provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

(B) If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

(i) shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

(ii) may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in subdivision (4) Effect on the Benefits of This Plan.

(2) Definitions.

(A) A "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment.

(i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage, but not student accident or student accident & health coverage, for which the student or parent pays the entire premium.

(ii) Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical

Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program. It also does not include group contracts issued by or reinsured through the Health Reinsurance Association, or subscriber contracts issued by a residual market mechanism established by hospital and medical service corporations and providing comprehensive health care coverage as provided in the Connecticut Health Care Act as now constituted or later amended.

Each contract or other arrangement for coverage under (i) or (ii) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

(B) “This Plan” is the part of the group contract that provides benefits for health care expenses.

(C) “Primary Plan”/“Secondary Plan.” The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be Secondary Plan as to a different Plan or Plans.

(Reference: Rules in subsection 38a-480-5 (a) (1) below.)

(D) “Allowable Expense” means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient’s stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

(Reference: Rule in subsection 38a-480-5 (d) below.)

(E) “Claim Determination Period” means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

(3) Order of benefit determination rules.

(A) General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

(i) the other Plan has rules coordinating its benefits with those of This Plan; and
(ii) both those rules and This Plan’s rules, in subparagraph (B) below, require that This Plan’s benefits be determined before those of the other Plan.

(B) Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(i) Non-dependent/Dependent. 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.

(ii) Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph (B) (iii) below, when This Plan and another Plan cover the same child as a dependent of different persons called “parents”:

(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; but

(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.

However, if the other Plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

(Reference: Rules in subsection 38a-480-5 (a) (2) below.)

(iii) Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) first, the Plan of the parent with custody of the child;

(b) then, the Plan of the spouse of the parent with the custody of the child; and

(c) finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one 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. This paragraph 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.

(iv) Active/Inactive Employee: 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 rule, and if, as a result, the Plans do not agree on the order of benefits, this rule (iv) is ignored.

(v) Longer/Shorter Length of Coverage. If none of the above rules determines 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 time.

(Reference: Rules in subsection 38a-480-5 (a) (3) below.)

(4) Effect on the benefits of this plan.

(A) When this Section applies. This subdivision (4) applies when, in accordance with subdivision (3) Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as “the other Plan” in (B) immediately below.

(B) Reduction in This Plan’s Benefits. The benefits of This Plan will be reduced when the sum of:

(i) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

(ii) 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 COB provision, whether or not claim is made; exceeds those Allowable Expenses in a

Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

(5) Right to Receive and Release Needed Information.

Certain facts are needed to apply these COB rules. (The XYZ Company) has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. (The XYZ Company) need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give (The XYZ Company) any facts it needs to pay the claim.

(Reference: Rules in subsections 38a-480-5 (e) below.)

(6) Facility of Payment.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, (The XYZ Company) may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. (The XYZ Company) will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

(Reference: Rules in subsections 38a-480-5 (e) below.)

(7) Right of Recovery

If the amount of the payments made by (The XYZ Company) is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- (A) the persons it has paid or for whom it has paid;
- (B) insurance companies; or
- (C) other organizations.

The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

(Reference: Rules in subsection 38a-480-5 (e) below.)

(Effective September 25, 1992)

Sec. 38a-480-5. Rules for coordination of benefits

(a) **Order of Benefits.**

(1) General.

(A) The Primary Plan must pay or provide its benefits as if the Secondary Plan or Plans did not exist.

(B) A Secondary Plan may take the benefits of another Plan into account only when, under these rules, it is Secondary to that other Plan.

(Reference: subsections 38a-480-4 (c) and 38a-480-4 (d) (2) (C) above.)

(2) Dependent Child/Parents Not Separated or Divorced.

(A) The word “birthday” in the wording shown in subsection 38a-480-4 (d) (3) (B) (ii) of this regulation refers only to month and day in a calendar year, not the year in which the person was born.

(Reference: subsections 38a-480-4 (d) (3) (B) (ii) above.)

(3) Longer/Shorter Length of Coverage.

(A) To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new Plan does not include:

- (i) a change in the amount or scope of a Plan’s benefits;

(ii) a change in the entity which pays, provides or administers the Plan's benefits; or

(iii) a change from one type of Plan to another (such as, from a single employer plan to that of a multiple employer plan).

(B) The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that 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.

(Reference: subsection 38a-480-4 (d) (3) (B) (v) above.)

(b) **Reasonable Cash Value of Services.** 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 provision 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.

(c) **Excess and Other Nonconforming Provisions.**

(1) Some Plans have order of benefit determination rules not consistent with this regulation which declare that the Plan's coverage is "excess" to all others, or "always secondary." This occurs because: (A) certain Plans may not be subject to insurance regulation; or (B) some group contracts have not yet been conformed with this regulation pursuant to Section 38a-480-7, Effective Date Existing Contract.

(2) A Plan with order of benefit determination rules which comply with this regulation (herein called a Complying Plan) may coordinate its benefits with a Plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in this regulation (herein called a Noncomplying Plan) on the following basis:

(A) If the Complying Plan is the Primary Plan, it shall pay or provide its benefits on a primary basis.

(B) 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.

(C) 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.

(D) If:

(i) the Noncomplying Plan reduces its benefits so that the employee, subscriber, or member receives less in benefits that 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 (ii) governing state law allows the right of subrogation set forth below; then the Complying Plan shall advance to or on behalf of the employee, subscriber, or member an amount equal to such difference. However, 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.

(Reference: subsections 38a-480-4 (d) (4), (5), (6) and (7) above.)

(d) **Allowable Expense.** 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 COB provisions apply.

(Reference: subsection 38a-480-4 (d) (2) (D) above.)

(e) **Subrogation.** The COB 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.

(Reference: subsections 38a-480-4 (d) (4), (5), (6) and (7) above.)

(Effective September 25, 1992)

Sec. 38a-480-6. Effect on mandated benefits; spouse coverage

(a) **Mandated Benefits.** Nothing in this regulation may be used so as to diminish the benefits due under a Primary Plan or Secondary Plan with regard to benefits that are mandated by any statute or public act of the State of Connecticut.

(b) **Spouse Coverage.** Nothing in this regulation may be used to negate the provisions of Connecticut General Statutes Section 38a-541.

(Effective September 25, 1992)

Sec. 38a-480-7. Effective date; existing contracts

This regulation takes effect on April 1, 1988.

It applies to every group contract which provides health care benefits and is issued on or after that date.

A group contract which provides health care benefits and was issued before that date shall be brought into compliance with this regulation by the later of: (a) the next anniversary date or renewal date of the group contract; or (b) the expiration of any applicable collectively bargained contract pursuant to which it was written.

(Effective September 25, 1992)

Approval of Group Accident, Group Health, and Group Accident and Health Policy Forms

Sec. 38a-480-8. Definitions

As used in Sections 38a-480-8 through 38a-480-10, inclusive:

(a) “Commissioner” means the Insurance Commissioner of this state.

(b) “Form” means a policy of insurance against loss or expense from sickness, or from bodily injury or death by accident, issued upon a group plan, or application, certificate, rider or endorsement used in connection therewith.

(c) “Insurer” means an insurance company licensed by the Commissioner to write accident and health insurance.

(Effective September 25, 1992)

Sec. 38a-480-9. Filing procedure

Any insurer required pursuant to Section 38a-480 (a) (2) of the General Statutes to file a copy of a form with the Commissioner for approval, shall comply with the following standards:

(a) **Filing Transmittal Letter.**

(1) The filing transmittal letter should be sent to the attention of the Life and Health Division of the Insurance Department.

(2) If one or more elements within a filing vary by member company within a group of companies, the filer shall send a separate filing transmittal letter for each insurer within the group.

(3) The filer shall enclose a return copy of the transmittal letter(s) along with a stamped self-addressed return envelope of a size sufficient to return the duplicate copies of the filing to the insurer, and one letter size self-addressed stamped envelope to provide the notice required by Section 38a-480-10 (a).

(4) The filing transmittal letter shall contain a descriptive caption. The caption shall identify the insurer when the insurer is a member of an affiliated group of insurers using generic letterhead. The caption shall also include a brief description of the type of filing, and any applicable form identification number. All subsequent correspondence to the Insurance Department on the filing shall include the caption in the identical format as it was displayed in the original filing transmittal letter, in addition to the date of the original filing transmittal letter (and the Department's file number, if known).

(5) The body of the filing transmittal letter shall list the documents submitted therewith, briefly outline proposed changes, the approval sought, and specify the proposed effective date. When the form(s) sought to be approved by the Commissioner are not subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, the filing transmittal letter shall so state such fact.

(6) The insurer shall provide in the filing transmittal letter a telephone number for readily contacting the person responsible for submitting the filing.

(b) All forms filed with the Insurance Department in accordance with this section shall be filed in duplicate. All such filings must be submitted in a clearly legible condition.

(c) All form filings shall include a separate document for the disclosure of the intended use of the form and the method it will be marketed. Such disclosure document, which will delimit the scope of the Commissioner's approval of the form, shall contain in numerical sequence the following:

(1) Information on exactly how the form will be marketed (i.e. individual basis, mass merchandised, association membership, union membership etc.);

(2) The market for which the form is intended (especially note markets such as over age 65, key men, professionals, etc.);

(3) The underwriting basis used, note especially any deviation from standard underwriting rules (medical, non-medical, guaranteed issue, simplified application, etc.);

(4) Any limitation of the use of the form by certain agents or brokers;

(5) An explanation of any change in benefits which occur while the contract is in force with a reference to the contract provisions which relate to the benefit change;

(6) A notation and explanation of any deviation from the insurer's usual retention; and

(7) Any additional information which may be necessary to completely understand the form and its use in this state.

(d) Every form filing shall be completed in "John Doe" fashion.

(e) (1) Every form filing subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, shall be accompanied with a

certificate signed by an officer of the insurer, that the form complies with the Insurance Plain Language Act.

(2) The certificate required by subdivision (1) of this subsection shall be in the following form:

(NAME OF COMPANY)
(COMPANY ADDRESS)

This is to certify that the forms listed below are in compliance with Chapter 699a of the Connecticut General Statutes.

A. Option Selected

_____ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____.

_____ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:

Form	Form Number	Flesch Score
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B. Test Option Selected

_____ 1. Test was applied to entire policy form(s)

_____ 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. Standards for Certification

A checked block indicates the standard has been achieved.

_____ 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

_____ 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)

_____ 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

_____ 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.

_____ 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

_____ 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsement or riders.

_____ 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

(COMPANY NAME)

_____ By: _____
(Date) (Title)

(f) When an insurer makes reference to another document in its filing, it must include a copy and fully disclose the referenced document.

(g) The Insurance Department is obligated to collect, pursuant to Section 12-211 of the General Statutes, form filing fees from foreign or alien insurers, if the state or foreign country in which they are domiciled imposes such (and larger) fees upon Connecticut's domestic insurers. Accordingly, each insurer domiciled in any other state or jurisdiction which requires such fees shall remit the equivalent filing fee (in the form of a check made payable to the Treasurer, State of Connecticut) together

with each such filing submitted. The insurer shall also represent and certify that the fee payment remitted is the same amount required by its domiciliary state or jurisdiction.

(Effective September 25, 1992)

Sec. 38a-480-10. Policy form approval

(a) Within fifteen (15) days of receipt of a form filed with the Commissioner for approval pursuant to Section 38a-480 (a) (2) of the General Statutes, the Insurance Department shall determine a filing to be complete or deficient for purposes of submission for review and shall issue written notice to the insurer regarding the status of the form.

(1) The written notice for a complete filing shall state that the form filing is complete and accepted for filing for review as of the date of its receipt. For purposes of this section, a form filing is complete upon agency determination that it is in compliance with Section 38a-480-9.

(2) The written notice for a deficient filing shall state that the form filing is deficient and not accepted for filing and shall set out the specific items that must be corrected to make the form complete. In addition to this notice, the Insurance Department may notify the insurer, in any manner, of problems with the form.

(b) Unless otherwise provided by law, the Insurance Department shall review all forms filed with the Insurance Commissioner for approval pursuant to Section 38a-480 (a) (2) of the General Statutes in the order in which they are received by the Department; provided, however, that in appropriate circumstances the Commissioner may waive this requirement and direct the immediate review of a form filing. The Department shall employ a chronological logging system to facilitate the chronological review of such forms.

(c) Within seventy-five (75) days after a form is accepted for review, the Insurance Department shall review the form and either approve it or disapprove it. If, upon such review of the form, the Insurance Department determines that additional information from the insurer is necessary in order to ascertain whether the form is contrary to law or is unfair, deceptive or may encourage misrepresentation of the policy, the Department shall make such request to the insurer. The insurer will then have thirty (30) days from the date of the request to provide the Department with the additional information; provided that during such time, the insurer may request in writing that the period for responding to the request for information be extended for an additional period of time, not to exceed sixty (60) days. The request for extension shall be considered granted upon its receipt by the Insurance Department. During the pendency of the Insurance Department's request for information, the seventy-five (75) day period for Department action shall be tolled. If the insurer fails to comply with such request within the allotted time, the insurer shall be deemed to have voluntarily withdrawn its filing and the Department shall close its file without further action.

(d) The Commissioner shall issue an order disapproving the use of any such form if it does not comply with the requirements of law, or if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy. Any such order shall specify the reason for disapproval of the form.

(e) Forms that are approved by the Commissioner shall have the form and the extra copy of the filing transmittal letter stamped "Approved," together with the name and signature of the staff member who acted upon the filing and the date of the approval.

(Effective September 25, 1992)

Sec. 38a-480-10a. Electronic filing

(a) Any insurer filing a copy of a form with the commissioner in accordance with section 38a-480-9 of the Regulations of Connecticut State Agencies may submit such form electronically using software known as the System for Electronic Rate and Form Filing (SERFF), Version 2.0 or higher, or any subsequent corresponding system, adopted by the National Association of Insurance Commissioners. All such filings shall include the information required in section 38a-480-9 of the Regulations of Connecticut State Agencies.

(b) Filings made electronically shall be considered received by the commissioner when received at the Insurance Department. Filings received on a weekend or legal holiday shall be deemed received on the next business day. An electronic communication from the Insurance Department concerning a filing shall be deemed received by the person to whom the communication is addressed when the communication is sent.

(Adopted effective January 2, 2002)

**Approval of Form of Life Insurance, Endowment and Annuity Policies
and Contracts Providing Additional Benefits for Accidental
Death and Waiver of Premium Benefits****Sec. 38a-480-11. Definitions**

As used in Section 38a-480-11 through 38a-480-14, inclusive:

(a) "Commissioner" means the Insurance Commissioner of this state.

(b) "Form" means a life insurance, endowment or annuity contract or contracts supplemental thereto which contain only such provisions relating to accident and health insurance as (1) provide additional benefits in case of death by accidental means and (2) 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 become totally and permanently disabled as defined by the contract or supplemental contract.

(c) "Insurer" means an insurance company licensed by the Commissioner to write life insurance.

(Effective September 25, 1992)

Sec. 38a-480-12. Filing procedure

Any insurer required pursuant to Section 38a-480 (a) (3) of the General Statutes to file a copy of a form with the Commissioner for approval, shall comply with the following standards:

(a) Filing Transmittal Letter.

(1) The filing transmittal letter should be sent to the attention of the Life and Health Division of the Insurance Department.

(2) If one or more elements within a filing vary by member company within a group of companies, the filer shall send a separate filing transmittal letter for each insurer within the group.

(3) The filer shall enclose a return copy of the transmittal letter(s) along with a stamped self-addressed return envelope of a size sufficient to return the duplicate copies of the filing to the insurer, and one letter size self-addressed stamped envelope to provide the notice required by Section 38a-480-13 (a).

(4) The filing transmittal letter shall contain a descriptive caption. The caption shall identify the insurer when the insurer is a member of an affiliated group of insurers using generic letterhead. The caption shall also include a brief description

of the type of filing, and any applicable form identification number. All subsequent correspondence to the Insurance Department on the filing shall include the caption in the identical form as it was displayed in the original filing transmittal letter, in addition to the date of the original filing transmittal letter (and the Department's file number, if known).

(5) The body of the filing transmittal letter shall list the documents submitted therewith, briefly outline proposed changes, the approval sought, and specify the proposed effective date. When the form(s) sought to be approved by the Commissioner are not subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, the filing transmittal letter shall so state such fact.

(6) The insurer shall provide in the filing transmittal letter a telephone number for readily contacting the person responsible for submitting the filing.

(b) All forms filed with the Insurance Department in accordance with this section shall be filed in duplicate. All such filings must be submitted in a clearly legible condition.

(c) All form filings shall include a separate document for the disclosure of the intended use of the form and the method it will be marketed. Such disclosure document, which will delimit the scope of the Commissioner's approval of the form, shall contain in numerical sequence the following:

(1) Information on exactly how the form will be marketed (i.e. individual basis, mass merchandised, association membership, union membership etc.);

(2) The market for which the form is intended (especially note markets such as over age 65, key men, professionals, etc.);

(3) The underwriting basis used, note especially any deviation from standard underwriting rules (medical, non-medical, guaranteed issue, simplified application, etc.);

(4) Any limitation of the use of the form by certain agents or brokers;

(5) An explanation of any change in benefits which occur while the contract is in force with a reference to the contract provisions which relate to the benefit change;

(6) For individual forms, disclosure of whether the commissions and gross premium rates are consistent with those of the company's individual policies. If the assumptions underlying the premium rates differ from the insurer's regular individual policies, an explanation shall be given of the difference, and the reason that use of the form does not result in unfair discrimination;

(7) A notation and explanation of any deviation from the insurer's usual retention; and

(8) Any additional information which may be necessary to completely understand the form and its use in this state.

(d) Every form filing shall be completed in "John Doe" fashion.

(e) (1) Every form filing subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, shall be accompanied with a certificate signed by an officer of the insurer that the form complies with the Insurance Plain Language Act.

(2) The certificate required by subdivision (1) of this subsection shall be in the following form:

(NAME OF COMPANY)

(COMPANY ADDRESS)

This is to certify that the forms listed below are in compliance with Chapter 699a of the Connecticut General Statutes.

A. Option Selected

- _____ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____.
- _____ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:

Form	Form Number	Flesch Score
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B. Test Option Selected

- _____ 1. Test was applied to entire form(s)
- _____ 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. Standards for Certification

A checked block indicates the standard has been achieved.

- _____ 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.
- _____ 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)
- _____ 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.
- _____ 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.
- _____ 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.
- _____ 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsement or riders.
- _____ 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

(COMPANY NAME)

_____ By: _____
 (Date) (Title)

(f) Each form filing other than those involving group life, group annuities and group accident and health insurance, shall be accompanied with the rates that will be used in connection with such form.

(g) When an insurer makes reference to another document in its filing, it must include a copy and fully disclose the referenced document.

(h) The Insurance Department is obligated to collect, pursuant to Section 12-211 of the General Statutes, form filing fees from foreign or alien insurers, if the state or foreign country in which they are domiciled imposes such (and larger) fees upon Connecticut's domestic insurers. Accordingly, each insurer domiciled in any other state or jurisdiction which requires such fees shall remit the equivalent filing fee (in the form of a check made payable to the Treasurer, State of Connecticut) together

with each such filing submitted. The insurer shall also represent and certify that the fee payment remitted is the same amount required by its domiciliary state or jurisdiction.

(Effective September 25, 1992)

Sec. 38a-480-13. Policy form approval

(a) Within fifteen (15) days of receipt of a form filed with the Commissioner for approval pursuant to Section 38a-480 (a) (3) of the General Statutes, the Insurance Department shall determine a filing to be complete or deficient for purposes of submission for review and shall issue written notice to the insurer regarding the status of the form.

(1) The written notice for a complete filing shall state that the form filing is complete and accepted for filing for review as of the date of its receipt. For purposes of this section, a form filing is complete upon agency determination that it is in compliance with Section 38a-480-12.

(2) The written notice for a deficient filing shall state that the form filing is deficient and not accepted for filing and shall set out the specific items that must be corrected to make the form complete. In addition to this notice, the Insurance Department may notify the insurer, in any manner, of problems with the form.

(b) Unless otherwise provided by law, the Insurance Department shall review all forms filed with the Insurance Commissioner for approval pursuant to Section 38a-480 (a) (3) of the General Statutes in the order in which they are received by the Department; provided, however, that in appropriate circumstances the Commissioner may waive this requirement and direct the immediate review of a form filing. The Department shall employ a chronological logging system to facilitate the chronological review of such forms.

(c) Within seventy-five (75) days after a form is accepted for review, the Insurance Department shall review the form and either approve it or disapprove it. If, upon such review of the form, the Insurance Department determines that additional information from the insurer is necessary in order to ascertain whether the form is contrary to law or is unfair, deceptive or may encourage misrepresentation of the policy, the Department shall make such request to the insurer. The insurer will then have thirty (30) days from the date of the request to provide the Department with the additional information; provided that during such time, the insurer may request in writing that the period for responding to the request for information be extended for an additional period of time, not to exceed sixty (60) days. The request for extension shall be considered granted upon its receipt by the Insurance Department. During the pendency of the Insurance Department's request for information, the seventy-five (75) day period for Department action shall be tolled. If the insurer fails to comply with such request within the allotted time, the insurer shall be deemed to have voluntarily withdrawn its filing and the Department shall close its file without further action.

(d) The Commissioner shall issue an order disapproving the use of any such form if it does not comply with the requirements of law, or if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy. Any such order shall specify the reason for disapproval of the form.

(e) Forms that are approved by the Commissioner shall have the form and the extra copy of the filing transmittal letter stamped "Approved," together with the name and signature of the staff member who acted upon the filing and the date of the approval.

(Effective September 25, 1992)

Sec. 38a-480-13a. Electronic filing

(a) Any insurer filing a copy of a form with the commissioner in accordance with section 38a-480-12 of the Regulations of Connecticut State Agencies may submit such form electronically using software known as the System for Electronic Rate and Form Filing (SERFF), Version 2.0 or higher, or any subsequent corresponding system, adopted by the National Association of Insurance Commissioners. All such filings shall include the information required in section 38a-480-12 of the Regulations of Connecticut State Agencies.

(b) Filings made electronically shall be considered received by the commissioner when received at the Insurance Department. Filings received on a weekend or legal holiday shall be deemed received on the next business day. An electronic communication from the Insurance Department concerning a filing shall be deemed received by the person to whom the communication is addressed when the communication is sent to that person.

(Adopted effective January 2, 2002)

Sec. 38a-480-14. Severability

If any provision of this regulation or 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.

(Effective September 25, 1992)

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Approval of Individual Accident and Health Policy Forms

Sec. 38a-481-1. Definitions

As used in this regulation:

- (a) "Commissioner" means the Insurance Commissioner of this state.
 - (b) "Form" means a policy of insurance against loss or expense from sickness, or from bodily injury or death by accident, or application, rider or endorsement used in connection therewith.
 - (c) "Insurer" means an insurance company licensed by the Commissioner to write accident and health insurance.
- (Effective September 25, 1992)

Sec. 38a-481-2. Filing procedure

Any insurer required pursuant to Section 38a-481 of the General Statutes to file a copy of a form with the Commissioner for approval, shall comply with the following standards:

(a) **Filing Transmittal Letter.**

(1) The filing transmittal letter should be sent to the attention of the Life and Health Division of the Insurance Department.

(2) If one or more elements within a filing vary by member company within a group of companies, the filer shall send a separate filing transmittal letter for each insurer within the group.

(3) The filer shall enclose a return copy of the transmittal letter(s) along with a stamped self-addressed return envelope of a size sufficient to return the duplicate copies of the filing to the insurer, and one letter size self-addressed stamped envelope to provide the notice required by Section 38a-481-3 (a).

(4) The filing transmittal letter shall contain a descriptive caption. The caption shall identify the insurer when the insurer is a member of an affiliated group of insurers using generic letterhead. The caption shall also include a brief description of the type of filing, and any applicable form identification number. All subsequent correspondence to the Insurance Department on the filing shall include the caption in the identical format as it was displayed in the original filing transmittal letter, in addition to the date of the original filing transmittal letter (and the Department's file number, if known).

(5) The body of the filing transmittal letter shall list the documents submitted therewith, briefly outline proposed changes, the approval sought, and specify the proposed effective date. When the form(s) sought to be approved by the Commissioner are not subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, the filing transmittal letter shall disclose such fact.

(6) The insurer shall provide in the filing transmittal letter a telephone number for readily contacting the person responsible for submitting the filing.

(b) All forms filed with the Insurance Department in accordance with this section shall be filed in duplicate. All such filings must be submitted in a clearly legible condition.

(c) All form filings shall include a separate document for the disclosure of the intended use of the form and the method it will be marketed. Such disclosure document, which will delimit the scope of the Commissioner's approval of the form, shall contain in numerical sequence the following:

(1) Information on exactly how the form will be marketed (i.e. individual basis, mass merchandised, association membership, union membership etc.);

(2) The market for which the form is intended (especially note markets such as over age 65, key men, professionals, etc.);

(3) The underwriting basis used, noting especially any deviation from standard underwriting rules (medical, non-medical, guaranteed issue, simplified application, etc.);

(4) Any limitation of the use of the form by certain agents or brokers;

(5) An explanation of any change in benefits which occur while the contract is in force with a reference to the contract provisions which relate to the benefit change;

(6) Disclosure of whether the commissions and gross premium rates are consistent with those of the company's individual policies. If the assumptions underlying the premium rates differ from the insurer's regular individual policies, an explanation shall be given of the difference, and the reason that use of the form does not result in unfair discrimination;

(7) A notation and explanation of any deviation from the insurer's usual retention; and

(8) Any additional information which may be necessary to completely understand the form and its use in this state.

(d) Every form filing shall be completed in "John Doe" fashion.

(e) (1) Every form filing subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, shall be accompanied with a certificate signed by an officer of the insurer, that the form complies with the Insurance Plain Language Act.

(2) The certificate required by subdivision (1) of this subsection shall be in the following form:

(NAME OF COMPANY)

(COMPANY ADDRESS)

This is to certify that the forms listed below are in compliance with Chapter 699a of the Connecticut General Statutes.

A. Option Selected

_____ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____.

_____ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:

Form	Form Number	Flesch Score
------	-------------	--------------

B. Test Option Selected

_____ 1. Test was applied to entire form(s)

_____ 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. Standards for Certification

A checked block indicates the standard has been achieved.

_____ 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

_____ 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)

_____ 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

- _____ 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.
- _____ 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.
- _____ 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsement or riders.
- _____ 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

(COMPANY NAME)

 (Date) By: _____
 (Title)

(f) Each form filing other than those involving group accident and health insurance, shall be accompanied with the classification of risks and the premium rates, or in the case of cooperatives or assessment companies, the estimated cost that will be used in connection with such form.

(g) When an insurer makes reference to another document in its filing, it must include a copy and fully disclose the referenced document.

(h) The Insurance Department is obligated to collect, pursuant to Section 12-211 of the General Statutes, form filing fees from foreign or alien insurers, if the state in which they are domiciled imposes such (and larger) fees upon Connecticut's domestic insurers. Accordingly, each insurer domiciled in any other state or jurisdiction which requires such fees shall remit the equivalent filing fee (in the form of a check made payable to the Treasurer, State of Connecticut) together with each such filing submitted. The insurer shall also represent and certify that the fee payment remitted is the same amount required by its domiciliary state or jurisdiction.

(Effective September 25, 1992)

Sec. 38a-481-3. Policy form approval

(a) Within fifteen (15) days of receipt of a form filed with the Commissioner for approval pursuant to Section 38a-481 of the General Statutes, the Insurance Department shall determine a filing to be complete or deficient for purposes of submission for review and shall issue written notice to the insurer regarding the status of the form.

(1) The written notice for a complete filing shall state that the form filing is complete and accepted for filing for review as of the date of its receipt. For purposes of this section, a form filing is complete upon agency determination that it is in compliance with Section 38a-481-2.

(2) The written notice for a deficient filing shall state that the form filing is deficient and not accepted for filing and shall set out the specific items that must be corrected to make the form complete. In addition to this notice, the Insurance Department may notify the insurer, in any manner, of problems with the form.

(b) Unless otherwise provided by law, the Insurance Department shall review all forms filed with the Insurance Commissioner for approval pursuant to Section 38a-481 of the General Statutes in the order in which they are received by the Department; provided, however, that in appropriate circumstances the Commissioner may waive this requirement and direct the immediate review of a form filing. The Department shall employ a chronological logging system to facilitate the chronological review.

(c) Within seventy-five (75) days after a form is accepted for review, the Insurance Department shall review the form and either approve it or disapprove it. If, upon such review of the form, the Insurance Department determines that additional information from the insurer is necessary in order to ascertain whether the form is contrary to law or is unfair, deceptive or may encourage misrepresentation of the policy, the Department shall make such request to the insurer. The insurer will then have thirty (30) days from the date of the request to provide the Department with the additional information; provided that during such time, the insurer may request in writing that the period for responding to the request for information be extended for an additional period of time, not to exceed sixty (60) days. The request for extension shall be considered granted upon its receipt by the Insurance Department. During the pendency of the Insurance department's request for information, the seventy-five (75) day period for Department action shall be tolled. If the insurer fails to comply with such request within the allotted time, such applicant shall be deemed to have voluntarily withdrawn its filing and the Department shall close its file without further action.

(d) The Commissioner shall issue an order disapproving the use of any such form if it does not comply with the requirements of law, or if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy. Any such order shall specify the reason for disapproval of the form.

(e) Forms that are approved by the Commissioner shall have the form and the extra copy of the filing transmittal letter stamped "Approved," together with the name and signature of the staff member who acted upon the filing and the date of the approval.

(Effective September 25, 1992)

Sec. 38a-481-3a. Electronic filing

(a) Any insurer filing a copy of a form with the commissioner in accordance with section 38a-481-2 of the Regulations of Connecticut State Agencies may submit such form electronically using software known as the System for Electronic Rate and Form Filing (SERFF), Version 2.0 or higher, or any subsequent corresponding system, adopted by the National Association of Insurance Commissioners. All such filings shall include the information required in section 38a-481-2 of the Regulations of Connecticut State Agencies.

(b) Filings made electronically shall be considered received by the commissioner when received at the Insurance Department. Filings received on a weekend or legal holiday shall be deemed received on the next business day. An electronic communication from the Insurance Department concerning a filing shall be deemed received by the person to whom the communication is addressed when the communication is sent to that person.

(Adopted effective January 2, 2002)

Sec. 38a-481-4. Severability

If any provision of this regulation or 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.

(Effective September 25, 1992)

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Medicare Supplement Insurance Minimum Standards

Sec. 38a-495-1. Applicability and scope

Except as otherwise specifically provided, Sections 38a-495-1 to 38a-495-13, inclusive, shall apply to:

(a) All Medicare supplement policies and subscriber contracts delivered or issued for delivery in this State on or after the effective date hereof, and

(b) All certificates issued under group Medicare supplement policies or subscriber contracts, which certificates have been delivered or issued for delivery in this State.

(Effective September 25, 1992)

Sec. 38a-495-2. Definitions

As used in Sections 38a-495-1 to 38a-495-13, inclusive:

(a) "Applicant" means:

(1) in the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits, and

(2) in the case of a group Medicare supplement policy or subscriber contract, the proposed certificateholder;

(b) "Certificate" means any certificate issued under a group Medicare supplement policy, which certificate has been delivered or issued for delivery in this State;

(c) "Commissioner" means the Insurance Commissioner of the State of Connecticut;

(d) "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended (Title I, Part I of P.L. 89-97);

(e) "Medicare supplement policy" means any individual or group accident and sickness insurance policy or certificate or individual subscriber contract delivered or issued for delivery to any resident of this state who is eligible for Medicare except any long-term care policy as defined in Section 38-174x of the General Statutes.

(f) "Medicare eligible expenses" mean health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare.

(g) "Medigap policy" means a Medicare Supplement policy specifically designed to cover the co-payments not covered by Medicare and to pay Medicare eligible expenses after Medicare's limits have been reached.

(Effective September 25, 1992)

Sec. 38a-495-3. Policy definitions and terms

No Medicare Supplement policy may be advertised, solicited or issued for delivery to any resident in this State who is eligible for Medicare unless such policy or subscriber contract contains definitions or terms which conform to the requirements of this section.

(a) "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.

(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) Such 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.

(b) "Benefit Period" or "Medicare Benefit Period" shall not be defined as more restrictive than as that defined in the Medicare program.

(c) "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall be defined in relation to its status, facilities and available services.

(1) A definition of such home or facility shall not be more restrictive than one requiring that it:

(A) be operated pursuant to law;

(B) be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

(C) be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(D) provide continuous twenty-four (24) hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

(E) maintains a daily medical record of each patient.

(2) The definition of such home or facility may provide that such term not be inclusive of: (A) any home, facility or part thereof used primarily for rest; (B) a home or facility for the aged or for the care of drug addicts or alcoholics; or (C) a home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

(d) "Health Care Expenses" means expenses of health maintenance organizations associated with the delivery of health care services which are analogous to incurred losses of insurers. Such expenses shall not include: (1) home office and overhead costs; (2) advertising costs; (3) commissions and other acquisition costs; (4) taxes; (5) capital costs; (6) administrative costs; or (7) claims processing costs.

(e) "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.

(1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital: (A) be an institution operated pursuant to law, and; (B) be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which charge is made; and (C) provide twenty-four (24) hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s).

(2) The definition of the term "hospital" may state that such term shall not be inclusive of: (A) convalescent homes, convalescent, rest or nursing facilities; or (B) facilities primarily affording custodial, educational or rehabilitative care; or (C) facilities for the aged, drug addicts or alcoholics; or (D) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(f) "Medicare" shall be defined in the policy. 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 Aged

Act, as then constituted and any later amendments or substitutes thereof,” or words of similar import.

(g) “Medicare Eligible Expenses” shall mean health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity as are applicable to Medicare claims;

(h) “Mental or Nervous Disorders” shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(i) “Nurses” may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words “nurse,” “trained nurse,” or “registered nurse” are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualified under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the State.

(j) “Physician” may be defined by including words such as “fully qualified physician” or “duly licensed physician.” The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider’s licensed authority and are provided pursuant to applicable laws.

(k) “Sickness” shall not be defined to be more restrictive than the following: “Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.” The definition may be further modified to exclude sickness or diseases for which benefits are provided under any workers’ compensation, occupational disease, employer’s liability or similar law.

(Effective September 25, 1992)

Sec. 38a-495-4. Prohibited policy provisions

(a) No insurance policy or subscriber contract which provides benefits to any resident of this State who is eligible for Medicare may be advertised, solicited or issued for delivery in this State if such policy or subscriber contract limits or excludes coverage by type of illness, accident, treatment or medical condition, except as follows:

(1) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

(2) mental or emotional disorders, alcoholism and drug addiction;

(3) illness, treatment or medical condition arising out of: (A) war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or units auxiliary thereto; (B) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; (C) aviation;

(4) cosmetic surgery, except that “cosmetic surgery” shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;

(5) Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effect thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column;

(6) treatment provided in a governmental hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(7) dental care or treatment;

(8) eye glasses, hearing aids and examination for the prescription or fitting thereof;

(9) rest cures, custodial care, transportation and routine physical examinations;

(10) territorial limitations outside the United States; provided, however, supplemental policies may not contain, when issued, limitations or exclusions of the type enumerated in Subsections (1), (5), (9), or (10) above that are more restrictive than those of Medicare. Medicare supplement policies may exclude coverage for any expense to the extent of any benefit available to the insured under Medicare.

(b) No Medicare supplement policy may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(c) The terms "Medicare Supplement," "Medigap" and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

(d) No Medicare supplement insurance policy, contract or certificate in force in the State shall contain benefits which duplicate benefits provided by Medicare.

(Effective September 25, 1992)

Sec. 38a-495-5. Minimum benefit standards

(a) No insurance policy or subscriber contract which provides benefits to any resident of this State may be advertised, solicited or issued for delivery in this State who is eligible for Medicare which does not meet the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(b) **General Standards.** The following standards apply to Medicare supplement policies and are in addition to all other requirements of Sections 38a-495-1 to 38a-495-17, inclusive.

(1) A Medicare supplement policy may not deny a claim for losses incurred more than six (6) months from the effective date of coverage for a preexisting condition. The policy 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 may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy 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 only with the prior approval of the Commissioner.

(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 cancelled or nonrenewed by the insurer solely on the grounds of deterioration of health.

(5) (A) Except as authorized by the Commissioner, an insurer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(B) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in paragraph (D) of this subdivision, the insurer shall offer certificateholders an individual Medicare supplement policy. The insurer shall offer the certificateholder at least the following choices:

(i) an individual Medicare supplement policy which provides for continuation of the benefits contained in the group policy; and

(ii) an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards.

(C) If membership in a group is terminated, the insurer shall:

(i) offer the certificateholder such conversion opportunities as are described in paragraph (B); or

(ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(D) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding insurer 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.

(6) Termination of a Medicare supplement policy 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 payment of the maximum benefits.

(c) **Minimum Benefit Standards.** The following standards apply to Medigap policies and are in addition to all other requirements of this regulation.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th 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 365 days.

(5) Coverage for the daily copayment amount of Medicare Part A eligible expenses for skilled nursing facility care.

(6) 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.

(7) Coverage for either all or none of the Medicare Part B deductible amount.

(8) No Medicare supplement policy shall provide coverage for amounts which exceed the co-payment for Medicare eligible expenses under Part B, unless such additional coverage will provide for reimbursement of 100 percent of the usual and

prevailing charges for Medical care. This 100 percent reimbursement shall not be made subject to any additional deductibles.

(9) 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.

(10) 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.

(d) **Medicare Eligible Expenses.** Medicare eligible expenses shall mean health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity as are applicable to Medicare claims.

(e) Any Medicare supplement policy which is not a Medigap policy shall be disapproved by the Commissioner if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy.

(Effective September 25, 1992)

Sec. 38a-495-6. Standard for claims payment

(a) Every entity providing Medicare supplement policies or contracts shall comply with all provisions of Section 4081 of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203).

(b) Compliance with the requirements set forth in Subsection (a) must be certified on the Medicare supplement insurance experience reporting form.

(Effective September 25, 1992)

Sec. 38a-495-7. Loss ratio standards

(a) Medicare supplement policies shall return to policyholders in the form of aggregate benefits under the policy, for the entire period for which rates are computed to provide coverage, 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:

(1) At least 70 percent of the aggregate amount of premiums earned in the case of group policies; and

(2) At least 75 percent of the aggregate amount of premiums earned in the case of group policies defined in Section 1882 (g) of Title XVIII of the Social Security Act, 42 U.S.C. 1395ss (g), as amended; and

(3) At least 65 percent of the aggregate amount of premiums earned in the case of individual policies.

All filings of rates and rating schedules shall demonstrate that actual and expected losses in relation to premiums comply with the requirements of this section.

(b) Every entity providing Medicare supplement policies in this State shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums and paid losses to written premiums by number of years of policy duration demonstrating that it is in compliance with the foregoing applicable loss ratio standards and that the period for which the policy is rated is reasonable in accordance with accepted actuarial principles and experience.

(c) As soon as practicable, but prior to the effective date of Medicare benefit changes every insurer, health care service plan or other entity providing Medicare supplement insurance or contracts in this State shall file with the Commissioner, in accordance with the applicable filing procedures of this state:

(1) (A) Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. Such supporting documents as necessary to justify the adjustment shall accompany the filing, and

(B) Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this State pursuant to Section 38a-495 of the General Statutes shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or contract as will conform with the 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 insurer, health care service plan or other entity for such Medicare supplement insurance policies or contracts. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare. Any such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.

(Effective September 25, 1992)

Sec. 38a-495-8. Filing requirements for out-of-state group policies

Every insurer providing group Medicare supplement insurance benefits to a resident of this State shall submit a copy of the master policy and any certificate and rates to be used in this State for approval prior to being issued in this State in accordance with the filing requirements and procedures applicable to group Medicare supplement policies issued in this State.

(Effective September 25, 1992)

Sec. 38a-495-9. Permitted compensation arrangements

(a) An insurer 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 200 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 a reasonable number of renewal years.

(c) No 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 insurer on renewal policies or certificates if an existing policy or certificate is replaced unless benefits of the new policy or certificate are clearly and substantially greater than the benefits under the replaced policy.

(d) For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

(Effective September 25, 1992)

Sec. 38a-495-10. Required disclosure provisions

(a) **General Rules.** (1) Medicare supplement policies shall include a renewal or continuation provision. The language or specifications of such provision must be consistent with the type of contract issued. Such provision shall be appropriately captioned, and shall appear on the first page of the policy.

(2) Except for riders or endorsements by which the insurer 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 date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement insurance 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) A Medicare supplement policy 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.

(4) If a Medicare supplement policy contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(5) Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policy or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded in a reasonably prompt manner if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6) Insurers issuing accident and sickness policies, certificates or subscriber contracts which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person(s) eligible for Medicare by reason of age shall provide to all applicants a Medicare supplement Buyer's Guide in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration. Delivery of the Buyer's Guide shall be made whether or not such policies, certificates or subscriber contracts are advertised, solicited or issued as Medicare supplement policies as defined in this regulation. Except in the case of direct response insurers, delivery of the Buyer's Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Buyer's Guide shall be obtained by the insurer. Direct response insurers shall deliver the Buyer's Guide to the applicant upon request but not later than at the time the policy is delivered.

(b) **Notice Requirements.** (1) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this State shall notify its policyholders, contract holders and certificate holders of modifications it has made to Medicare supplement insurance policies or contracts in a format acceptable to the Commissioner or in

the format prescribed in Appendix A, if no other format is prescribed by the Commissioner. Such notice shall: (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 insurance policy or contract, and (B) Inform each covered person as to when any premium adjustment approved by the commissioner 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) **Outline of Coverage Requirements for Medicare Supplement Policies.**

(1) Insurers issuing Medicare supplement policies or certificates for delivery in this State shall provide an outline of coverage to all applicants at the time application is made and, except for direct response policies, shall obtain an acknowledgement of receipt of such outline from the applicant; and

(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 which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve (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 pursuant to paragraphs (1) and (2) shall be in the form prescribed below:

[COMPANY NAME]
 OUTLINE OF MEDICARE
 SUPPLEMENT COVERAGE AND PREMIUM INFORMATION

USE THIS OUTLINE TO COMPARE BENEFITS
 AND PREMIUMS AMONG POLICIES

1. **Read your Policy Carefully**—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
2. **Medicare Supplement Coverage**—Policies of this category are designed to supplement Medicare by covering some hospital, medical and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to any deductibles and copayment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.
3. A. [for agents:]
 Neither [insert company's name] nor its agents are connected with Medicare.
 B. [for direct responses:]

- [insert company's name] is not connected with Medicare.
4. [A brief summary of the major medical benefit gaps in Medicare Parts A & B with a parallel description of supplemental benefits, including dollar amounts (and indexed copayments or deductibles, as appropriate), provided by the Medicare supplement coverage in the following order:]

DESCRIPTION	THIS POLICY PAYS**	YOU PAY
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I. MINIMUM STANDARDS

SERVICE

PART A

INPATIENT HOSPITAL SERVICES:

- Semi-Private Room & Board
- Miscellaneous Hospital Services
 - & Supplies, such as Drugs,
 - X-Rays, Lab Tests & Operating Room

SKILLED NURSING FACILITY CARE

BLOOD

HOME HEALTH SERVICES

PART B

MEDICAL EXPENSE:

- Services of a Physician/
 - Outpatient Services
- Medical Supplies other than
 - Prescribed Drugs

BLOOD

MAMMOGRAPHY SCREENING

MISCELLANEOUS

- Immunosuppressive Drugs

II. ADDITIONAL BENEFITS

PART A

DESCRIPTION	THIS POLICY PAYS**	YOU PAY
-------------	-----------------------	---------

Part A Deductible

- Private Rooms
- In-Hospital Private Nurses
- Skilled Nursing Facility Care

PARTS A & B

Part B Deductible

Medical Charges in Excess of
 Medicare Allowable Expenses
 (Percentage Paid)

OUT-OF-POCKET MAXIMUM

PRESCRIPTION DRUGS

MISCELLANEOUS

Respite Care Benefits
 Expenses Incurred in
 Foreign Country

Other:

TOTAL PREMIUM \$ _____

IN ADDITION TO THIS OUTLINE OF COVERAGE, [INSURANCE COMPANY NAME] WILL SEND AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

**If this policy does not provide coverage for a benefit listed above, the insurer must state “no coverage” beside that benefit in the first column.

5. [The following chart shall accompany the outline of coverage:]

[Company Name]

Notice of Changes in Medicare and your Medicare
 Supplement Coverage—1990

The following chart briefly describes the modifications in Medicare and in your medicare supplement coverage. **PLEASE READ CAREFULLY!**

[A brief description of the revisions to Medicare parts A & B with a parallel description of supplemental benefits with subsequent changes, including dollar amounts, provided by the Medicare supplement coverage in substantially the following format.]

SERVICES	MEDICARE BENEFITS Effective January 1, 1990, <u>Medicare Will Pay</u>	YOUR MEDICARE SUPPLEMENT COVERAGE Effective January 1, 1990, <u>Your Coverage Will Pay</u>
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MEDICARE PART A
 SERVICES AND SUPPLIES

Inpatient Hospital Services	All but \$592 for first 60 days/benefit period
Semi-Private Room & Board	All but \$148 a day for 61st– 90th days/benefit period

Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab. Tests & Operating Room	All but \$296 a day for 91st–150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)
BLOOD	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period
SKILLED NURSING FACILITY CARE	100% of costs for 1st 20 days (after a 3 day prior hospital confinement)/benefit period
	All but \$74.00 a day for 21st–100th days/benefit period
	Beyond 100 days– Nothing/benefit period
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$75 deductible/calendar year)
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after \$75 deductible/calendar year)
BLOOD	80% of costs except nonreplacement fees (blood deductible) for first 3 pints (after \$75 deductible/calendar year)

[Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage. If there are corresponding Medicare benefits, they should be shown.]

[Describe any coverage provisions changing due to Medicare modifications.]

[Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.]

This chart summarizing the changes in your Medicare benefits and in your Medicare supplement provided by [Company] only briefly describes such benefits. For

information on your Medicare benefits contact your Social Security Office or the Health Care Financing Administration. For information on your Medicare supplement Policy contact:

[Company or for an individual policy—name of agent] [Address/phone number]

6. Statement that the policy does or does not cover the following: (A) Private duty nursing; (B) Skilled nursing home care costs (beyond what is covered by Medicare); (C) Custodial nursing home care costs; (D) Intermediate nursing home care costs; (E) Home health care above number of visits covered by Medicare; (F) Physician charges (above Medicare's reasonable charges); (G) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay); (H) Care received outside the U.S.A.; (I) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids.
7. A description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay, or in any other manner operate to qualify payments of the benefits described in 4 above, including conspicuous statements;
 - (a) That the chart summarizing Medicare benefits only briefly describes such benefits.
 - (b) That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.
8. A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.
9. The amount of premium for this policy.
[Note: The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate.]

(Effective September 25, 1992)

Sec. 38a-495-11. Requirements for application forms and replacement coverage

(a) 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 Medicare supplement 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, except where the coverage is sold without an agent, containing such questions may be used.

(1) Do you have another Medicare supplement insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

(2) Did you have another Medicare supplement policy or certificate in force during the last twelve (12) months?

(A) If so, with which company?

(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]?

(b) Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five (5) years which are no longer in force.

(c) All sales involving replacement shall be reported to the Commissioner by the replacing insurer within thirty (30) days of the effective date of the newly issued policy or certificate. The report shall include the name and address of the insured, the name of the company whose policy is being replaced and the name of the agent replacing the coverage. For sales involving replacement by an insurer other than a direct response insurer, this report shall also include a comparison of the coverage issued with that being replaced, including a comparison of the premiums and an explanation of how said replacement was beneficial to the insured.

(d) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage. One (1) copy of such 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 insurer. A direct response insurer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness coverage.

(e) The notice required by Subsection (d) above for an insurer, other than a direct response insurer, shall be provided in substantially the following form:

**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 lapse or otherwise terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. 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 coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement 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 of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

[NOTE: This subsection may be modified if preexisting conditions are covered under the new policy.]

2. 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) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing Medicare supplement 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)

(f) The notice required by Subsection (d) above for a direct response insurer shall be as follows:

**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 lapse or otherwise terminate existing Medicare supplement insurance and replace it with the policy delivered herewith issued by [Company Name] Insurance Company.

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 coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement 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 of a claim for 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, waiting periods, elimination periods or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, 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 Medicare supplement 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)

(Effective September 25, 1992)

Sec. 38a-495-12. Filing requirements for advertising

Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits in this State shall provide a copy of any Medicare supplement advertisement intended for use in this State whether through written, radio or television medium to the Commissioner for review or approval by the Commissioner to the extent it may be required under state law.

(Effective September 25, 1992)

Sec. 38a-495-13. Standards for marketing

(a) Every insurer, health care service plan or other entity marketing Medicare supplement insurance coverage in this state, directly or through its producers, shall:

(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 or the outline of coverage and policy the following:

“NOTICE TO BUYER: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.”

(4) 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.

(5) Every insurer or entity marketing Medicare supplement insurance shall establish auditable procedures for verifying compliance with this subsection.

(b) In addition to the practices prohibited in Section 38a-815 of the General Statutes 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 covert 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.

(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.

(Effective September 25, 1992)

Sec. 38a-495-14. Appropriateness of recommended purchase and excessive insurance

(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 which will provide an individual more than one Medicare supplement policy or certificate is prohibited; provided however, that additional Medicare supplement coverage may be sold if, when combined with that individual's health coverage already in force, it would insure no more than 100% of the individual's actual medical expenses covered under the combined policies.

(Effective September 25, 1992)

Sec. 38a-495-15. Reporting of multiple policies

On or before March 1, every insurer or other entity providing Medicare supplement insurance coverage in this State shall report the following information for every individual resident of this State for which the insurer or entity has in force more than one Medicare supplement insurance policy or certificate: (1) policy and certificate number, and (2) date of issuance. This information shall be grouped by individual policyholder.

(Effective September 25, 1992)

Sec. 38a-495-16. Prohibition against preexisting conditions, waiting periods, elimination periods and probationary periods in replacement policies or certificates

If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy for similar benefits to the extent such time was spent under the original policy.

(Effective September 25, 1992)

Sec. 38a-495-17. Separability

If any provision of this regulation 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.

(Effective September 25, 1992)

APPENDIX A

[Company Name]

Notice of Changes in Medicare and your Medicare Supplement Coverage—199X

The following chart briefly describes the modifications in Medicare and in your medicare supplement coverage. PLEASE READ THIS CAREFULLY!

[A brief description of the revisions to Medicare Parts A & B with a parallel description of supplemental benefits with subsequent changes, including dollar amounts, provided by the Medicare supplement coverage in substantially the following format.]

SERVICES	MEDICARE BENEFITS	YOUR MEDICARE SUPPLEMENT COVERAGE
	Effective January 1, 199X, Medicare Will Pay	Effective January 1, 199X, Your Coverage Will Pay

MEDICARE PART A SERVICES AND SUPPLIES

Inpatient Hospital Services

Semi-Private Room & Board

Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room

BLOOD

SKILLED NURSING FACILITY CARE

(Effective September 25, 1992)

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Medicare Supplement Insurance

Sec. 38a-495a-1. Applicability and scope

(a) Except as otherwise specifically provided, sections 38a-495a-1 to 38a-495a-21, inclusive, of the Regulations of Connecticut State Agencies shall apply to:

(1) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date hereof, and

(2) All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state on or after the effective date hereof.

(b) This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one 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.

(Effective July 30, 1992; amended December 1, 2005, November 30, 2009)

Sec. 38a-495a-2. Definitions

As used in Sections 38a-495a-1 to 38a-495a-20, inclusive:

As used in sections 38a-495a-1 to 38a-495a-20, inclusive, of the Regulations of Connecticut State Agencies:

(a) “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.

(b) “Bankruptcy” means when a Medicare Advantage 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 the state.

(c) “Certificate” means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

(d) “Certificate Form” means the form on which the certificate is delivered or issued for delivery by the issuer.

(e) “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.

(f) (1) “Creditable coverage” means, with respect to an individual, coverage of the individual provided under any of the following:

(A) a group health plan;

(B) health insurance coverage;

(C) part a or part b of title xviii of the Social Security Act (Medicare);

(D) title xix of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;

(E) chapter 55 of title 10 United States Code (medical and dental coverage);

(F) a medical care program of the Indian Health Service or of a tribal organization;

(G) a state health benefits risk pool;

(H) a health plan offered under chapter 89 of title 5 United States Code (federal employees health benefits program);

(I) a public health plan as defined in federal regulation; and

(J) a health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

(2) “Creditable coverage” shall not include one or more, or any combination of, the following:

(A) coverage only for accident or disability income insurance, or any combination thereof;

(B) coverage issued as a supplement to liability insurance;

(C) liability insurance, including general liability insurance and automobile liability insurance;

(D) workers’ compensation or similar insurance;

(E) automobile medical payment insurance;

(F) credit-only insurance;

(G) coverage for on-site medical clinics; and

(H) other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) “Creditable coverage” 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:

(A) limited scope dental or vision benefits;

(B) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(C) such other similar, limited benefits as are specified in federal regulations.

(4) “Creditable coverage” shall not include the following benefits if offered as independent, noncoordinated benefits:

(A) coverage only for a specified disease or illness; and

(B) hospital indemnity or other fixed indemnity insurance.

(5) “Creditable coverage” shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

(A) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(B) coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and

(C) similar supplemental coverage provided to coverage under a group health plan.

(g) “Employee welfare benefit plan” means a plan, fund or program of employee benefits as defined in 29 U.S.C. section 1002 (Employee Retirement Income Security Act).

(h) “Insolvency” means when an issuer, licensed to transact the business of insurance in this state, 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.

(i) “Issuer” includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, health care centers, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

(j) “Medicare” means the “Health Insurance for the Aged Act,” Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(k) “Medicare Advantage plan” means a plan of coverage for health benefits under Medicare part C, and includes:

(1) Coordinated care plans which provide health care services, including but not limited to health care center plans, with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and

(3) Medicare Advantage private fee-for-service plans.

(l) “Medicare supplement policy” means a group or individual policy of insurance or a subscriber contract, other than a policy issued pursuant to a contract under section 1876 of the federal Social Security Act (42 U.S.C. section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. s 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. “Medicare supplement policy” does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under § 1833(a)(1)(A) of the Social Security Act.

(m) “Policy form” means the form on which the policy is delivered or issued for delivery by the issuer.

(n) “Pre-standardized plan” means a group or individual policy of Medicare supplement insurance issued prior to July 30, 1992.

(o) “1992 Standardized Medicare supplement benefit plan”, “1992 Standardized benefit plan” or “1992 plan” means a group or individual policy of Medicare supplement insurance issued on or after July 30, 1992, and with an effective date for coverage prior to June 1, 2010.

(p) “2010 Standardized Medicare supplement benefit plan”, “2010 Standardized benefit plan” or “2010 plan” means a group or individual policy of Medicare supplement insurance issued with an effective date for coverage on or after June 1, 2010.

(q) “Secretary” means the secretary of the United States Department of Health and Human Services.

(Effective July 30, 1992, amended June 2, 1998, November 9, 1999, December 10, 2002, December 1, 2005, November 30, 2009)

Sec. 38a-495a-3. Policy definitions and terms

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 section.

(a) “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.

(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) Such 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.

(b) “Benefit Period” or “Medicare Benefit Period” shall not be defined more restrictively than as defined in the Medicare program.

(c) “Convalescent Nursing Home,” “Extended Care Facility,” or “Skilled Nursing Facility” shall not be defined more restrictively than as defined in the Medicare program.

(d) “Health Care Expenses” as used in section 38a-495a-10 of the Regulations of Connecticut State Agencies means expenses of health care centers associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

(e) “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.

(f) “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.

(g) “Medicare Eligible Expenses” shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

(h) “Physician” shall not be defined more restrictively than as defined in the Medicare program.

(i) “Sickness” shall not be defined to be more restrictive than the following: “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.”

The definition 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.

(Effective July 30, 1992; amended December 1, 2005, November 30, 2009)

Sec. 38a-495a-4. Policy provisions

(a) Except for permitted preexisting condition clauses as described in section 38a-495a-5(a) (1) of the Regulations of Connecticut State Agencies, no policy or certificate may 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.

(d) (1) Subject to sections 38a-495a-5(a) (4), 38a-495a-5(a) (5) and 38a-495a-5(a) (7) of the Regulations of Connecticut State Agencies, a Medicare supplement policy with benefits for outpatient prescription drugs in existence as of December 31, 2005 shall be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

(2) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(3) After December 31, 2005, a Medicare Supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

(A) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Medicare Part D plan and;

(B) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

(Effective July 30, 1992; amended December 1, 2005, November 30, 2009)

Sec. 38a-495a-5. Benefit standards for policies or certificates issued or delivered on or after July 30, 1992 and with an effective date for coverage prior to June 2010

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 30, 1992 and with an effective date for coverage prior to June 2010. 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 these benefit standards.

(a) **General Standards.** The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(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, copayment or coinsurance amounts. Premiums may be modified to correspond with such changes only with the prior approval of the commissioner.

(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;

(A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(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 subparagraph (E) of this subdivision, the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

(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 certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(i) Offer the certificateholder the conversion opportunity described in subparagraph (C) of this subdivision, or

(ii) At the option of the group policyholder, offer the certificateholder 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. Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.

(7) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

(8) (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 certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder 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 certificateholder 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 certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificateholder 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) Each Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder or certificateholder if the policyholder or certificate holder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan (as defined in section 1862(b)(1)(A)(v) of the Social Security Act). If such suspension occurs, and if the policyholder or certificateholder loses coverage under the group health plan, the policy or certificate shall be automatically reinstated (effective as of the date of loss of such coverage) if the policyholder or certificateholder provides notice of loss of coverage within 90 days after the date of such loss of coverage.

(D) Reinstatement of coverage as described in subparagraphs (B) and (C) of this subdivision:

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for resumption of coverage which is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare

supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(9) If an issuer makes a written offer to the Medicare supplement policyholders or certificateholders of one or more of its plans, to exchange during a specified period his or her 1992 standardized benefit plan as described in section 38a-495a-6 of the Regulations of Connecticut State Agencies, for a 2010 standardized benefit plan as described in section 38a-495a-6a of the Regulations of Connecticut State Agencies, the offer and subsequent exchange shall comply with the following requirements:

(A) An issuer may not apply new pre-existing limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1992 standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six months to any added benefits contained in the new 2010 standardized benefit plan not contained in the exchanged plan.

(B) The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan except where the offer or issue would be in violation of state or federal law.

(b) Standards for Basic (“Core”) Benefits Common to All Benefit Plans.

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.

(1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th 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 one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer’s payment as payment in full and may not bill the insured for any balance;

(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, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(c) Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans “B” through “J” only as provided by section 38a-495a-6 of the Regulations of Connecticut State Agencies.

(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 21st day through the 100th day in a Medicare benefit period for posthospital 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. The outpatient prescription drug benefit may be included for new sales in a Medicare supplement policy no later than December 31, 2005.

(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. The outpatient prescription drug benefit may be included for new sales in a Medicare supplement policy no later than December 31, 2005.

(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" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) (A) Preventive Medical Care Benefit: Coverage for the following preventive health services:

(i) An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (B) of this subdivision and patient education to address preventive health care measures.

(ii) Preventive screening tests or preventive services, the selection and frequency of which is determined by the attending physician.

(B) 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.

(A) For purposes of this benefit, 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/home-maker, 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 4 hours in a 24-hour period of services provided by a care provider is one visit.

(B) **Coverage Requirements and Limitations.**

(i) At-home recovery services provided shall be primarily services which assist in activities of daily living.

(ii) The insured’s attending physician shall 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: (I) 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; (II) The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit; (III) One thousand six hundred dollars (\$1,600) per calendar year; (IV) Seven (7) visits in any one week; (V) Care furnished on a visiting basis in the insured’s home; (VI) Services provided by a care provider as defined in this section; (VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded; (VIII) 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.

(C) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

(d) **Standards for Plans K and L.**

(1) Standardized Medicare supplement benefit plan “K” shall consist of the following: (A) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period; (B) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period; (C) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve

days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance; (D) Medicare Part A deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (J) of this subdivision; (E) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (J) of this subdivision; (F) Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (J) of this subdivision; (G) Coverage for fifty percent (50%), under Medicare Part A or B, of 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 until the out-of-pocket limitation is met as described in subparagraph (J) of this subdivision; (H) Except for coverage provided in subparagraph (I) of this subdivision, coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph (J) of this subdivision; (I) Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and (J) Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary.

(2) Standardized Medicare supplement benefit plan "L" shall consist of the following: (A) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period; (B) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period; (C) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance; (D) Medicare Part A deductible: Coverage for seventy-five percent (75%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (J) of this subdivision; (E) Skilled Nursing Facility Care: Coverage for seventy-five percent (75%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (J) of this subdivision; (F) Hospice Care: Coverage for seventy-five percent (75%) of cost

sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (J) of this subdivision; (G) Coverage for seventy-five percent (75%), under Medicare Part A or B, of 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 until the out-of-pocket limitation is met as described in subparagraph (J) of this subdivision; (H) Except for coverage provided in subparagraph (I) of this subdivision, coverage for seventy-five percent (75%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph (J) of this subdivision; (I) Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and (J) Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of \$2000 in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary. (Effective July 30, 1992; amended January 30, 1997, November 9, 1999, December 10, 2002, December 1, 2005, November 30, 2009)

Sec. 38a-495a-5a. Benefit standards for 2010 standardized Medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate on or after June 1, 2010 unless it complies with these benefit standards. No issuer may offer any 1992 Medicare standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage on or after July 30, 1992, and before June 1, 2010, remain subject to the requirements of 38a-495a-5 and 38a-495a-6 of the Regulations of Connecticut State Agencies.

(a) General Standards.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six 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 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, copayment, or coinsurance amounts. 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.

(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 a Medicare supplement policy is terminated by a group policyholder and is not replaced as provided under subparagraph (E) of this subdivision of this section, the issuer shall offer certificateholders an individual Medicare supplement policy which, at the option of the certificateholder, (i) provides for continuation of the benefits contained in the group policy, or (ii) provides for benefits that otherwise meet the requirements of this subsection.

(D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall offer the certificateholder (i) the conversion opportunity described in subparagraph (C) of this subdivision, or (ii) at the option of the group policyholder, 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. Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.

(7) (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 certificateholder for the period, not to exceed 24 months, in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, provided the policyholder or certificateholder notifies the issuer of the policy or certificate not later than ninety days after the date the individual becomes entitled to assistance.

(B) If such suspension occurs and the policyholder or certificateholder loses entitlement to medical assistance under Title XIX of the Social Security Act, the policy or certificate shall be automatically reinstated effective as of the date of termination of entitlement provided the policyholder or certificateholder provides notice of loss of entitlement not later than ninety days after the date of loss and pays the premium attributable to the period.

(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended, for any period that may be provided by federal regulation, at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan, as defined in section 1862 (b) (1) (A) (v) of the Social Security Act. If such suspension occurs and the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstated effective as of the date of loss of coverage, provided the policyholder provides notice of loss of coverage not later than ninety days after the date of the loss and pays the premium

attributable to the period as of the date of termination of enrollment in the group health plan.

(D) Reinstitution of coverages as set forth in subparagraphs (B) and (C) of this subdivision shall (i) not provide for any waiting period with respect to treatment of preexisting conditions, and (ii) shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension.

(b) Standards for Basic Core Benefits Common to Medicare Supplement Plans A, B, C, D, F, F with High Deductible G, M, and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate that includes 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 of it:

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th 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 one hundred percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three 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, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(6) Hospice Care: coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(c) Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit plans B, C, D, F, F with High Deductible, G, M, and N as set forth in section 38a-495a-6a of the Regulations of Connecticut State Agencies:

(1) Medicare Part A Deductible: Coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

(2) Medicare Part A Deductible: Coverage for fifty percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

(3) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;

(4) Medicare Part B Deductible: Coverage for one hundred percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

(5) One Hundred Percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to

exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge;

(6) **Medically Necessary Emergency Care in a Foreign Country:** Coverage to the extent not covered by Medicare for eighty percent 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 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$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.

(Adopted effective November 30, 2009)

Sec. 38a-495a-6. Standard Medicare supplement benefit plans for 1992 standardized Medicare supplement benefit plan policies or certificates issued for delivery on or after July 30, 1992 and with an effective date for coverage prior to June 1, 2010

(a) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic “core” benefits, as defined in section 38a-495a-5(b) of the Regulations of Connecticut State Agencies.

(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 sections 38a-495a-6(f) (3) and 38a-495a-7 of the Regulations of Connecticut State Agencies.

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans “A” through “L” listed in this section and conform to the definitions in section 38a-495a-2 of the Regulations of Connecticut State Agencies. Each benefit shall be structured in accordance with the format provided in sections 38a-495-5(b) and 38a-495a-5(c) of the Regulations of Connecticut State Agencies and list the benefits in the order shown in this subsection. For purposes of 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) of this section, other designations to the extent permitted by law.

(e) Make-up of benefit plans:

(1) Standardized Medicare supplement benefit plan “A” shall be limited to the Basic (“Core”) Benefits Common to All Benefit Plans, as defined in section 38a-495a-5(b) of the Regulations of Connecticut State Agencies.

(2) Standardized Medicare supplement benefit plan “B” shall include only the following: The Core Benefit as defined in section 38a-495a-5(b) of the Regulations of Connecticut State Agencies, plus the Medicare Part A Deductible as defined in section 38a-495a-5(c) (1) of the Regulations of Connecticut State Agencies.

(3) Standardized Medicare supplement benefit plan “C” shall include only the following: The Core Benefit as defined in 38a-495a-5(b) of the Regulations of Connecticut State Agencies, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in sections 38a-495a-5(c) (1), (2), (3) and (8) of the Regulations of Connecticut State Agencies respectively.

(4) Standardized Medicare supplement benefit plan “D” shall include only the following: The Core Benefit as defined in section 38a-495a-5(b) of the Regulations

of Connecticut State Agencies, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in sections 38a-495a-5(c) (1), (2), (8) and (10) of the Regulations of Connecticut State Agencies respectively.

(5) Standardized Medicare supplement benefit plan "E" shall include only the following: The Core Benefit as defined in section 38a-495a-5(b) of the Regulations of Connecticut State Agencies, plus the Medicare Part A deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in sections 38a-495a-5(c) (1), (2), (8) and (9) of the Regulations of Connecticut State Agencies respectively.

(6) Standardized Medicare supplement benefit plan "F" shall include only the following: The Core Benefit as defined in section 38a-495a-5(b) of the Regulations of Connecticut State Agencies, plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in sections 38a-495a-5(c) (1), (2), (3), (5) and (8) of the Regulations of Connecticut State Agencies respectively.

(7) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 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 section 38a-495a-5(b) of the Regulations of Connecticut State Agencies, plus the Medicare part a deductible, skilled nursing facility care, the Medicare part B deductible, one hundred percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in sections 38a-495a-5(c) (1), (2), (3), (5) and (8) of the Regulations of Connecticut State Agencies 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 for 1998 and 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-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(8) Standardized Medicare supplement benefit plan "G" shall include only the following: The Core Benefit as defined in section 38a-495a-5(b) of the Regulations of Connecticut State Agencies, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Eighty Percent (80%) of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in sections 38a-495a-5(c) (1), (2), (4), (8) and (10) respectively of the Regulations of Connecticut State Agencies.

(9) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit as defined in section 38a-495a-5(b) of the Regulations of Connecticut State Agencies, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in sections 38a-495a-5(c) (1), (2), (6) and (8) of the Regulations of Connecticut State Agencies respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(10) Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit as defined in section 38a-495a-5(b) of the Regulations of

Connecticut State Agencies, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in sections 38a-495a-5(c) (1), (2), (5), (6), (8) and (10) of the Regulations of Connecticut State Agencies respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(11) Standardized Medicare supplement benefit plan "J" shall consist of only the following: The Core Benefit as defined in section 38a-495a-5(b) of the Regulations of Connecticut State Agencies, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in sections 38a-495a-5(c) (1), (2), (3), (5), (7), (8), (9) and (10) of the Regulations of Connecticut State Agencies respectively. The outpatient prescription drug benefit plan shall not be included in a Medicare supplement policy sold after December 31, 2005.

(12) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 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 section 38a-495a-5(b) of the Regulations of Connecticut State Agencies, plus the Medicare part A deductible, skilled nursing facility care, Medicare part B deductible, one hundred percent (100%) of the Medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in sections 38a-495a-5(c) (1), (2), (3), (5), (7), (8), (9) and (10) of the Regulations of Connecticut State Agencies 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 deductible shall be one thousand five hundred dollars for 1998 and 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-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars. The outpatient prescription drug benefit plan shall not be included in a Medicare supplement policy sold after December 31, 2005.

(f) Make-up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);

(1) Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in section 38a-495a-5(d) (1) of the Regulations of Connecticut State Agencies.

(2) Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in section 38a-495a-5(d) (2) of the Regulations of Connecticut State Agencies.

(3) New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates 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. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

(Effective July 30, 1992; amended November 9, 1999, December 1, 2005, November 30, 2009)

Sec. 38a-495a-6a. Standard Medicare supplement benefit plans for 2010 standardized Medicare supplement benefit plan policies or certificates with an effective date for coverage on or after June 10, 2010

(a) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate on or after June 1, 2010 unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date for coverage on or after July 30, 1992, and before June 1, 2010, remain subject to the requirements of sections 38a-495a-5 and 38a-495a-6 of the Regulations of Connecticut State Agencies.

(1) (A) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in section 38a-495a-5a of the Regulations of the Connecticut State Agencies.

(B) If an issuer makes available any of the additional benefits set forth in section 38a-495a-5a(c) of the Regulations of Connecticut State Agencies or offers standardized benefit plan K or L as set forth in this section, the issuer shall also make available to each prospective policyholder and certificateholder standardized benefit plan C or F, as set forth in this section, in addition to the basic core benefit plan required under subparagraph (A) of this subdivision.

(b) No groups, packages or combinations of Medicare supplement benefits other than those listed in this section and section 38a-495a-7 of the Regulations of Connecticut State Agencies shall be offered for sale in this state.

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this section and conform to the definitions in section 38a-495a-2 of the Regulations of Connecticut State Agencies. Each benefit shall be structured in accordance with section 38a-495a-5a of the Regulations of Connecticut State Agencies, or, in the case of plans K or L, this section, and list the benefits in the order shown. For purposes of this section, “structure”, “language”, “designation” and “format” means style, arrangement and overall content of a benefit.

(d) In addition to the benefit plan designation required in subsection (c) of this section, an issuer may use other designations to the extent permitted by law.

(e) Make-up of 2010 standardized benefit plans:

(1) Standardized Medicare supplement benefit plan A shall include only the following: The basic core benefit as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies.

(2) Standardized Medicare supplement benefit plan B shall include only the following: The basic core benefit as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies, plus one hundred percent of the Medicare Part A deductible, as set forth in section 38a-495a-5a(c) (1) of the Regulations of Connecticut State Agencies.

(3) Standardized Medicare supplement benefit plan C shall include only the following: The basic core benefit as set forth in section 38a-495a-5a(b) of the

Regulations of Connecticut State Agencies, plus one hundred percent of the Medicare Part A deductible, skilled nursing facility care, one hundred percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country, as set forth in section 38a-495a-5a(c) of the Regulations of Connecticut State Agencies.

(4) Standardized Medicare supplement benefit plan D shall include only the following: The basic core benefit as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies, plus one hundred percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as set forth in section 38a-495a-5a(c) of the Regulations of Connecticut State Agencies.

(5) Standardized Medicare supplement plan F shall include only the following: The basic core benefits as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies, plus one hundred percent of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent of the Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, as set forth in section 38a-495a-5a(c) of the Regulations of Connecticut State Agencies.

(6) Standardized Medicare supplement plan F with High Deductible shall include only the following:

(A) The basic core benefit as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies, plus one hundred percent of the Medicare Part A deductible, skilled nursing facility care, one hundred percent of the Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, as set forth in section 38a-495a-5a(c) of the Regulations of Connecticut State Agencies, plus one hundred percent of covered expenses following payment of the annual deductible set forth in subparagraph (B) of this subdivision.

(B) The annual deductible in plan F with High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be \$1500 and shall be adjusted annually from 1999 by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(7) Standardized Medicare supplement plan G shall include only the following: The basic core benefit as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies, plus one hundred percent of the Medicare Part A deductible, skilled nursing facility care, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, as set forth in section 38a-495a-5a(c) of the Regulations of Connecticut State Agencies.

(8) Standardized Medicare supplement plan K shall include only the following:

(A) Part A hospital coinsurance 61st through 90th days: Coverage of one hundred percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(B) Part A hospital coinsurance, 91st through 150th days: Coverage of one hundred percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(C) Part A hospitalization after 150 days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one

hundred percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept issuer's payment as payment in full and may not bill the insured for any balance;

(D) Medicare Part A deductible: Coverage for fifty percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as set forth in subparagraph (J) of this subdivision;

(E) Skilled Nursing Facility Care: Coverage for fifty percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as set forth in subparagraph (J) of this subdivision;

(F) Hospice Coverage: Coverage for fifty percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as set forth in subparagraph (J) of this subdivision;

(G) Blood: Coverage for fifty percent under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as set forth in subparagraph (J) of this subdivision;

(H) Part B Cost Sharing: Except for coverage provided in subparagraph (I) of this subdivision, coverage for fifty percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as set forth in subparagraph (J) of this subdivision:

(I) Part B Preventive Services: Coverage of one hundred percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(J) Cost Sharing After Out-Of-Pocket Limits: Coverage of one hundred percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of \$4620 in 2009, indexed each year by the appropriate inflation adjustment specified by the secretary.

(9) Standardized Medicare supplement plan L shall include only the following:

(A) The benefits set forth in subparagraphs (A), (B), (C) and (I) of subdivision (8) of this subsection;

(B) The benefits set forth in subparagraphs (D), (E), (F) and (G) of subdivision (8) of this subsection, but substituting seventy-five percent for fifty percent, and

(C) The benefit set forth in subparagraph (J) of subdivision (8) of this subsection, but substituting \$2310 for \$4620.

(10) Standardized Medicare supplement plan M shall include only the following: The basic core benefits as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies, plus fifty percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as set forth in section 38a-495a-5a(c) of the Regulations of Connecticut State Agencies.

(11) Standardized Medicare supplement plan N shall include only the following: The basic core benefits as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies, plus one hundred percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care

in a foreign country, as set forth in section 38a-495a-5a(c) of the Regulations of Connecticut State Agencies with copayments in the following amounts:

(A) the lesser of twenty dollars or the Medicare Part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists; and

(B) the lesser of fifty dollars or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(f) New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer new or innovative benefits in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits shall not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

(Adopted effective November 30, 2009)

Sec. 38a-495a-7. Medicare select policies and certificates

(a) (1) This section shall apply to Medicare Select policies and certificates, as defined in this section.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(b) For the purposes of 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” mean 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 within which an issuer is authorized to offer a Medicare Select policy.

(c) The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the commissioner finds that the issuer has satisfied all of the requirements of this regulation.

(d) 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.

(e) A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. 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 that:

(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 paragraph 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:

(A) The formal organizational structure;

(B) The written criteria for selection, retention and removal of network providers; and

(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 (i).

(7) Any other information requested by the commissioner.

(f) (1) 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 prior to implementing such changes. Such changes shall be considered approved by the commissioner after thirty (30) days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the commissioner at least quarterly.

(g) A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network 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) is not reasonable to obtain such services through a network provider.

(h) 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.

(i) 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:

- (A) Other Medicare supplement policies or certificates offered by the issuer; and
- (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. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in Plans K and L.

(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.

(j) 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 pursuant to subsection (i) of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

(k) 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.

(1) The grievance procedure shall be described in the policy 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 31st to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

(l) 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.

(m) (1) 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 which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare supplement policy or certificate has been in force for six (6) months.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this subdivision, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(n) Medicare Select policies and certificates shall provide for continuation of coverage in the event the secretary determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(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 which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

(o) 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.

(Effective July 30, 1992; amended December 10, 2002, December 1, 2005, November 30, 2009)

Sec. 38a-495a-8. Open enrollment

(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 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 issuer shall be made available to all applicants who qualify under this subsection without regard to age.

(b) (1) If an applicant qualifies under subsection (a) of this section 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.

(2) If the applicant qualifies under subsection (a) of this section 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 aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subsection.

(c) Except as provided in subsection (b) of this section and section 38a-495a-19 of the Regulations of Connecticut State Agencies, subsection (a) of this section 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 certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

(Effective July 30, 1992; amended January 30, 1997, November 9, 1999, December 1, 2005, November 30, 2009)

Sec. 38a-495a-8a. Guaranteed issue for eligible persons

(a) Guaranteed Issue

(1) Eligible persons are those individuals described in subsection (b) of this section who seek to enroll under the policy during the period specified in subsection (c) of this section, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (e) of this section that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(b) Eligible Persons

An eligible person is an individual described in any of the following subdivisions:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a program of all-inclusive care for the elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(A) The certification of the organization or plan 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) (A) The individual is enrolled with:

(i) An eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost);

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(iii) An organization under an agreement under section 1833(a) (1) (A) of the Social Security Act (health care prepayment plan); or

(iv) An organization under a Medicare Select policy; and

(B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subdivision (2) of this subsection.

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(A) (i) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(ii) Of 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) (A) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and

(B) The subsequent enrollment described in subparagraph (A) of this subdivision is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

(6) The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Medicare Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (e) (4) of this section.

(c) Guaranteed issue time periods

(1) In the case of an individual described in subdivision (1) of subsection (b) of this section, the guaranteed issue period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if such notice is not received, notice that a claim has been denied because of such a termination or cessation) and ends 63 days after the date of the applicable notice;

(2) In the case of an individual described in subdivisions (2), (3), (5) or (6) of subsection (b) of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated;

(3) In the case of an individual described in subparagraph (A) of subdivision (4) of subsection (b) of this section, the guaranteed issue period begins on the earlier of: (A) The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other similar notice if any, and (B) the date that the applicable coverage is terminated, and ends 63 days after the date the coverage is terminated;

(4) In the case of an individual described in subdivision (2), (5) or (6) of subsection (b) of this section or subparagraph (B) or (C) of subdivision (4) of subsection (b) of this section who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date; and

(5) In the case of an individual described in subdivision (7) of subsection (b) of this section, the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v) (2) (B) of the Social Security Act from the Medicare supplement issuer during the sixty-day period immediately preceding the initial Medicare Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

(6) In the case of an individual described in subsection (b) but not described in the preceding subdivisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(d) Extended Medigap access for interrupted trial periods

(1) In the case of an individual described in subdivision (5) of subsection (b) of this section (or deemed to be so described, pursuant to this subdivision) whose enrollment with an organization or provider described in subparagraph (A) of subdivision (5) of subsection (b) of this section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in subdivision (5) of subsection (b) of this section;

(2) In the case of an individual described in subdivision (6) of subsection (b) of this section (or deemed to be so described, pursuant to this subdivision) whose enrollment with a plan or in a program described in subdivision (6) of subsection

(b) of this section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in subdivision (6) of subsection (b) of this section; and

(3) For purposes of subdivisions (5) and (6) of subsection (b) of this section no enrollment of an individual with an organization or provider described in subparagraph (A) of subdivision (5) of subsection (b) of this section, or with a plan or in a program described in subdivision (6) of subsection (b) of this section, may be deemed to be an initial enrollment under subdivisions (1) and (2) of this subsection after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

(e) Products to Which Eligible Persons are Entitled

The Medicare supplement policy to which eligible persons are entitled under:

(1) Subdivisions (1), (2), (3) and (4) of subsection (b) of this section is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F (including F with a high deductible), K or L offered by any issuer.

(2) Subdivision (5) of subsection (b) of this section is (A) the same 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 subdivision (1) of this subsection: (B) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or (C) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;

(3) Subdivision (6) of subsection (b) of this section shall include any Medicare supplement policy offered by any issuer.

(4) Subsection (b) (7) of this section is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

(f) Notification provisions

(1) At the time of an event described in subsection (b) of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (a) of this section. Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in subsection (b) of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (a) of this section. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

(Adopted effective November 9, 1999; amended December 10, 2002, December 1, 2005, November 30, 2009)

Sec. 38a-495a-9. Standards for claims payment

(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:

(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; and

(6) Providing to the secretary, 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) of this section shall be certified on the Medicare supplement insurance experience reporting form.

(Effective July 30, 1992; amended December 1, 2005, November 30, 2009)

Sec. 38a-495a-10. Loss ratio standards and refund or credit of premium

(a) Loss Ratio Standards

(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; and

(C) The provisions of subparagraphs (A) and (B) of this subsection shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health care center on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health care center shall not include:

(i) Home office and overhead costs;

(ii) Advertising costs;

(iii) Commissions and other acquisition costs;

(iv) Taxes;

(v) Capital costs;

(vi) Administrative costs; and

(vii) Claims processing costs.

(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.

(b) Refund or Credit Calculation

(1) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A 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, for policies issued prior to July 30, 1992, the issuer shall make the refund or credit calculation separately for all individual policies combined and all group policies combined for experience after the effective date of this paragraph. The first 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. Such 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, 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) Annual Filing of Premium Rates

An issuer of Medicare supplement policies and certificates issued before or after July 30, 1992 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 in accordance with the filing requirements and procedures prescribed by the commissioner. 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. 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, in accordance with the applicable filing procedures of this state:

(1) (A) 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.

(B) 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 herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(C) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

(2) 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.

(d) Public Hearings

The commissioner shall conduct a public hearing in accordance with section 38a-474 of the General Statutes to review the request by an issuer for an increase in a rate for a policy form or certificate form issued before or after July 30, 1992.

(Effective July 30, 1992; amended January 30, 1997, December 1, 2005, November 30, 2009)

Sec. 38a-495a-11. Filing and approval of policies and certificates and premium rates

(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 in accordance with filing requirements and procedures prescribed by the commissioner.

(b) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drugs as revised by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

(c) 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 in accordance with the filing requirements and procedures prescribed by the commissioner.

(d) (1) Except as provided in subdivision (2) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the commissioner, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(A) The inclusion of new or innovative benefits;

(B) The addition of either direct response or agent marketing methods;

(C) The addition of either guaranteed issue or underwritten coverage;

(D) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a “type” means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

(e) (1) Except as provided in subparagraph (A) of this subdivision, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. 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.

(A) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner 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, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(B) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph (A) of this subdivision 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 discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(3) A change in the rating structure or methodology shall be considered a discontinuance under subdivision (1) of this subsection unless the issuer complies with the following requirements:

(A) 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.

(B) 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.

(f) (1) Except as provided in subdivision (2) of this subsection, 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 section 38a-495a-10 of the Regulations of Connecticut State Agencies.

(2) 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.

(Effective July 30, 1992; amended December 1, 2005. November 30, 2009)

Sec. 38a-495a-12. Permitted compensation arrangements

(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 shall be the same as that provided in the second year or period and shall 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) For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders' fees.

(Effective July 30, 1992; amended January 30, 1997, December 1, 2005, November 30, 2009)

Sec. 38a-495a-13. Required disclosure provisions

(a) General Rules.

(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 and shall appear on the first page of the policy, and shall 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 date of issue or at reinstatement or renewal which 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 which 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 certificateholder 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) (A) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and Centers for Medicare and Medicaid Services 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 regulation. 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.

(B) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(b) Notice Requirements.

(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 certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. Such notice shall:

(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, and;

(B) Inform each policyholder or certificateholder 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) **MMA Notice Requirements.** Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(d) **Outline of Coverage Requirements for Medicare Supplement Policies.**

(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, and;

(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 which 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 twelve (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 pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans shall be shown on the cover page, and the plan(s) 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.

(4) The following items shall be included in the outline of coverage in the order prescribed below.

PREMIUM INFORMATION

We (insert issuer’s name) can only raise your premium if we raise the premium for all policies like yours in this state.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums for policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. (This paragraph shall not appear after June 1, 2011.)

READ YOUR POLICY VERY CAREFULLY

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

If you find that you are not satisfied with our 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

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

This 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 & You* handbook for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

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.

(Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to section 38a-495a-6a(d) of the Regulations of Connecticut State Agencies. For purposes of illustration, the charts below display in parentheses dollar amounts that vary in accordance with the Medicare program. Issuers shall revise such dollar amounts as necessary to ensure that outlines of coverage contain information that is current at the time the outlines are provided to consumers.)

(Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.)

(Illustrative charts follow)

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010
 This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in your state.
 Plans E, H, I, and J are no longer available for sale. (This sentence shall not appear after June 1, 2011).
 Basic Benefits:

- 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) or copayments for hospital outpatient services, Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
- Blood – First three pints of blood each year.
- Hospice – Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 50% basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER						
	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance					
	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible					
	Part B Deductible	Part B Deductible		Part B Deductible						
				Part B Excess (100%)	Part B Excess (100%)					
	Foreign Travel Emergency				Foreign Travel Emergency	Foreign Travel Emergency				
							Out-of-pocket limit (\$4620); paid at 100% after limit reached	Out-of-pocket limit (\$2310); paid at 100% after limit reached		

* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as plan F after one has paid a calendar year (\$2000) deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed (\$2000). 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 the plan's separate foreign travel emergency deductible.

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the Additional 365 days	All but \$(1,068) All but \$(267) a day All but \$(534) a day \$0 \$0	\$0 \$(267) a day All but \$(534) a day 100% of Medicare eligible expenses \$0	\$(1,068) (Part A Deductible) \$0 \$0 \$0** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$(133.50) a day \$0	\$0 \$0 \$0	\$0 Up to \$(133.50) a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****Notice:** When your Medicare Part A Hospital Benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$(135) of Medicare Approved Amounts*	\$0	\$0	\$(135) (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$(135) of Medicare Approved Amounts*	\$0	All Costs	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$(135) (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES— tests for diagnostic services	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE Medicare approved services —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$(135) of Medicare Approved Amounts*	100%	\$0	\$0
Remainder of Medicare Approved Amounts	\$80%	20%	\$(135) (Part B Deductible) \$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$(1,068)	\$(1,068) (Part A Deductible)	\$0
61 st thru 90th day	All but \$(267) a day	\$(267) a day	\$0
91 st day and after:			
—While using 60 lifetime reserve days	All but \$(534) a day	\$(534) a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
—Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$(133.50) a day	\$0	Up to \$(133.50) a day
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

** Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$(135) of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$(135) of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$(135) (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$(135) of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$(135) (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	\$0	\$0
First \$(135) of Medicare Approved Amounts*	\$0	\$0	\$(135) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$(1,068)	\$(1,068) (Part A Deductible)	\$0
61 st thru 90th day	All but \$(267) a day	\$(267) a day	\$0
91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days	All but \$(534) a day \$0	\$(534) a day 100% of Medicare Eligible Expenses	\$0 \$0**
—Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	All approved amounts	\$0	\$0
First 20 days	All but \$(133.50) a day	Up to \$(133.50) a day	\$0
21 st thru 100th day	\$0	\$0	All costs
101st day and after			
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare’s requirements including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN C
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

*Once you have been billed \$(135) of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$(135) of Medicare Approved Amounts*	\$0	\$(135) (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All Costs	\$0
Next \$(135) of Medicare Approved Amounts*	\$0	\$(135) (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$(135) of Medicare Approved Amounts*	100%	\$0	\$0
Remainder of Medicare Approved Amounts	\$0	\$(135) (Part B Deductible)	\$0
	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the Additional 365 days	All but \$(1,068) All but \$(267) a day All but \$(534) a day \$0 \$0	\$(1,068) (Part A Deductible) \$(267) a day \$(534) a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$(133.50) a day \$0	\$0 Up to \$(133.50) a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

** Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$(135) of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$(135) of Medicare Approved Amounts*	\$0	\$0	\$(135) (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All Costs	\$0
Next \$(135) of Medicare Approved Amounts*	\$0	\$0	\$(135) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$(135) of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services BEGINNING during the first 60 days of each trip outside the USA</p> <p>First \$250 each calendar year</p> <p>Remainder of Charges</p>	<p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250</p> <p>20% and amounts over the \$50,000 lifetime maximum</p>

**PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
 (**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$(2000) deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$(2000). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.)

SERVICES	MEDICARE PAYS	(AFTER YOU PAY \$(2000) DEDUCTIBLE,**) PLAN PAYS	(IN ADDITION TO \$(2000) DEDUCTIBLE,**) YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90 th day 91st day and after: —While using 60 Lifetime reserve days —Once lifetime reserve days are used: Additional 365 days —Beyond the Additional 365 days	All but \$(1068) All but \$(267) a day All but \$(534) a day \$0 \$0	\$(1068) (Part A Deductible) \$(267) a day \$(534) a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0*** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101 st day and after	All approved amounts All but \$(133.50) a day \$0	\$0 Up to \$(133.50) a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

***Notice: When your Medicare Part A Hospital Benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$(135) of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible WILL have been met for the calendar year.

(**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$(2000) deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$(2000). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.)

SERVICES	MEDICARE PAYS	(AFTER YOU PAY \$(2000) DEDUCTIBLE,**) PLAN PAYS	(IN ADDITION TO \$(2000) DEDUCTIBLE,**) YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$(135) of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$(135) (Part B Deductible) Generally 20%	\$0 \$0
Part B excess charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$(135) of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$(135) (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PLAN F or HIGH DEDUCTIBLE PLAN F
PARTS A & B**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$(2000) DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$(2000) DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	\$0	\$0
First \$(135) of Medicare Approved Amounts*	\$0	\$(135) (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$(2000) DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$(2000) DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the Additional 365 days	All but \$(1,068) All but \$(267) a day All but \$(534) a day \$0 \$0	\$(1068) (Part A Deductible) \$(267) a day \$(534) a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$(133.50) a day \$0	\$0 Up to \$(133.50) a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****Notice:** When your Medicare Part A Hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$(135) of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$(135) of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$(135) of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$(135) of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B Deductible) \$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$(4620) each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

***A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$(1068) All but \$(267) a day All but \$(534) a day \$0 \$0	\$(534)(50% of Part A deductible) \$(267) a day \$(534) a day 100% of Medicare Eligible Expenses \$0	\$(534)(50% of Part A deductible) ♦ \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$(133.50) a day \$0	\$0 Up to \$(66.75) a day \$0	\$0 Up to \$(66.75) a day ♦ All costs
BLOOD First 3 pints Additional amounts	\$0 100%	50% \$0	50% ♦ \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance ♦

*****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

****Once you have been billed \$(135) of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$(135) of Medicare Approved Amounts****	\$0	\$0	\$(135) (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved Amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$(4620))*
BLOOD First 3 pints Next \$(135) of Medicare Approved Amounts****	\$0 \$0	50% \$0	50% ♦ \$(135) (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$(4620) per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”)** and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**PLAN K
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$(135) of Medicare Approved Amounts***** Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 10%	\$0 \$(135) (Part B deductible) ♦ 10% ♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$(2310) each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$(1068) All but \$(267) a day All but \$(534) a day \$0 \$0	\$(801) (75% of Part A deductible) \$(267) a day \$(534) a day 100% of Medicare eligible expenses \$0	\$(267) (25% of Part A deductible)♦ \$0 \$0 \$0*** All Costs
SKILLED NURSING FACILITY CARE** You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$(133.50) a day \$0	\$0 Up to \$(100.13) a day \$0	\$0 Up to \$(33.38) a day♦ All costs
BLOOD First 3 pints Additional amounts	\$0 100%	75% \$0	25%♦ \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance or copayments	25% of copayment/coinsurance♦

*****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

****Once you have been billed \$(135) of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$(135) of Medicare Approved Amounts****	\$0	\$0	\$(135) (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$(2310))*
BLOOD First 3 pints Next \$(135) of Medicare Approved Amounts****	\$0	75%	25% ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	\$(135) (Part B deductible) ♦ Generally 5% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$(2310) per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”)** and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN L
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$(135) of Medicare Approved Amounts***** Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 15%	\$0 \$(135) (Part B deductible) ♦ 5% ♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*

PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$(1068) All but \$(267) a day All but \$(534) a day \$0 \$0	\$(534) (50% of Part A deductible) \$(267) a day \$(534) a day 100% of Medicare eligible expenses \$0	\$(534) (50% of Part A deductible) \$0 \$0 \$0** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$(133.50) a day \$0	\$0 Up to \$(133.50) a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$(135) of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$(135) of Medicare Approved Amounts*	\$0	\$0	\$(135) (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$(135) of Medicare Approved Amounts*	\$0	\$0	\$(135) (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN M

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$(135) of Medicare Approved Amounts*	\$0	\$0	\$(135) (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN M
OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$(1068)	\$(1068) (Part A Deductible)	\$0
61 st thru 90th day	All but \$(267) a day	\$(267) a day	\$0
91 st day and after: —While using 60 lifetime reserve days	All but \$(534) a day	\$(534) a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100th day	All but \$(133.50) a day	Up to \$(133.50) a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$(135) of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$(135) of Medicare Approved Amounts*	\$0	\$0	\$(135) (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to \$(20) per office visit and up to \$(50) per emergency room visit. The copayment of up to \$(50) is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to \$(20) per office visit and up to \$(50) per emergency room visit. The copayment of up to \$(50) is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$(135) of Medicare Approved Amounts*	\$0 \$0	All Costs \$0	\$0 \$(135) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$(135) of Medicare Approved Amounts*	100% \$0	\$0 \$0	\$0 \$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN N
OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

(d) Notice Regarding Policies or Certificates, Which Are Not Medicare Supplement Policies.

(1) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, a policy issued pursuant to a contract under section 1876 of the Federal Social Security Act (42 U.S.C. s 1395 et seq.), disability income policy; or other policy identified in section 38a-495a-1 of the Regulations of Connecticut State Agencies, 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. Such 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.

Such notice shall be in no less than twelve (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) of this subsection shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

(Effective July 30, 1992; amended January 30, 1997, June 2, 1998, December 10, 2002, December 1, 2005, November 30, 2009)

Sec. 38a-495a-14. Requirements for application forms and replacement coverage

(a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement coverage, Medicare Advantage, Medicaid coverage, or another 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 such questions and statements may be used.

(Statements)

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) 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 a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).

Questions

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

(Please mark Yes or No below with an "X")

To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months?

Yes____ No____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes____ No____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?

(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)

Yes____ No____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes____ No____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes ___ No ___

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START ___/___/___ END ___/___/___

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes ___ No ___

(c) Was this your first time in this type of Medicare plan?

Yes ___ No ___

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes ___ No ___

(4) (a) Do you have another Medicare supplement policy in force?

Yes ___ No ___

(b) If so, with what company, and what plan do you have (optional for Direct Mailers)?

 (c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes ___ No ___

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes ___ No ___

(a) If so, with what company and what kind of policy?

(b) What are your dates of coverage under the other policy?

___/___/___ END ___/___/___

(If you are still covered under the other policy, leave "END" blank.)

(b) Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies which are still in force.

(2) List policies sold in the past five (5) years which 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 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) of this section for an issuer shall be provided in substantially the following form in no less than twelve (12) point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

(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 or Medicare Advantage 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 or Medicare Advantage 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 or if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. (optional only for Direct Mailers.)
- Other. (please specify)

1. Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. 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 of a claim for 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, 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) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. 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) Paragraphs 1 and 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.

(Effective July 30, 1992; amended January 30, 1997, December 1, 2005, November 30, 2009)

Sec. 38a-495a-15. Filing requirements for advertising

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the commissioner for review or approval by the commissioner to the extent it may be required in accordance with regulations adopted pursuant to section 38a-819 of the General Statutes.

(Effective July 30, 1992; amended December 1, 2005, November 30, 2009)

Sec. 38a-495a-16. Standards for marketing

(a) An issuer, directly or through its producers, shall:

(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 policy the following:

“Notice to buyer: This policy may not cover all of your medical expenses.”

(4) 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.

(5) Establish auditable procedures for verifying compliance with this subsection (a).

(b) In addition to the practices prohibited in sections 38a-815 to 38a-831, inclusive, of the General Statutes 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 regulation.

(Effective July 30, 1992; amended January 30, 1997, December 1, 2005, November 30, 2009)

Sec. 38a-495a-17. Appropriateness of recommended purchase and excessive insurance

(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 Medicare supplement policy or certificate is prohibited.

(c) An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of coverage is after the termination date of the individual’s Part C coverage.

(Effective July 30, 1992; amended December 1, 2005, November 30, 2009)

Sec. 38a-495a-18. Reporting of multiple policies

(a) On or before March 1 of each year, an issuer shall report to the commissioner the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

- (1) Policy and certificate number, and
- (2) Date of issuance.

(b) The items set forth in subsection (a) of this section shall be grouped by individual policyholder.

(Effective July 30, 1992; amended December 1, 2005, November 30, 2009)

Sec. 38a-495a-19. Prohibition against preexisting conditions, waiting periods, elimination periods and probationary periods in replacement policies or certificates

(a) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, an employee group health insurance policy or certificate, or a policy or certificate issued by a health care center pursuant to a contract with the federal government, 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 for similar benefits to the extent such time was spent under the original policy or certificate.

(b) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, an employee group health insurance policy or certificate, or a policy or certificate issued by a health care center pursuant to a contract with the federal government, 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 for benefits similar to those contained in the original policy or certificate.

(Effective July 30, 1992; amended November 9, 1999, December 10, 2002, December 1, 2005, November 30, 2009)

Sec. 38a-495a-19a. Prohibition against use of genetic information. Requests for genetic testing

This section applies to all policies with policy years beginning on or after May 21, 2009.

(a) For the purposes of this section only:

(1) “Issuer of a Medicare supplement policy or certificate” includes third-party administrator, or other person acting for or on behalf of such issuer.

(2) “Family member” means, with respect to an individual, a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(3) “Genetic information” means, with respect to any individual, information about such individual’s genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. “Genetic information” includes any request for or receipt of genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term “genetic information” does not include information about the sex or age of any individual.

(4) “Genetic services” means (A) a genetic test, (B) genetic counseling (including obtaining, interpreting, or assessing genetic information), or (C) genetic education.

(5) “Genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term “genetic test” does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(6) “Underwriting purposes” means:

(A) rules for, or determination of, eligibility or continued eligibility for benefits under the policy;

(B) the computation of premium or contribution amounts under the policy;

(C) the application of any pre-existing condition exclusion under the policy; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(b) An issuer of a Medicare supplement policy or certificate:

(1) shall not deny or condition the issuance or effectiveness of the policy or certificate, including the imposition of any exclusion of benefits under the policy based on a preexisting condition, on the basis of an individual’s genetic information; and

(2) shall not discriminate in the pricing of the policy or certificate, including the adjustment of premium rates, of an individual on the basis of such individual’s genetic information.

(c) Nothing in subsection (b) of this section shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

(1) denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant or;

(2) increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. In such case, the manifestation of a disease or disorder in one individual shall not also be used as genetic information about other group members and to further increase the premium for the group.

(d) Except as provided in subsection (e) of this section, An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

(e) Subsection (d) of this section shall not be construed to preclude an issuer of a Medicare supplement policy from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with subsection (b) of this section.

(f) For purposes of carrying out subsection (e) of this section, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(g) An issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(1) the request is made pursuant to research that complies with 45 CFR 46, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research;

(2) the issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that (A) compliance with the request is voluntary, and (B) noncompliance will have no effect on enrollment status or premium or contribution amounts;

(3) no genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;

(4) the issuer notifies the secretary in writing that the issuer is conducting activities pursuant to this subsection, including a description of the activities conducted;

(5) the issuer complies with such other conditions as the secretary may by regulation require for activities conducted under this subsection.

(h) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

(i) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

(j) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subsection (i) of this section if such request, requirement, or purchase is not a violation of subsection (h) of this section.

(Adopted effective November 30, 2009)

Sec. 38a-495a-20. Separability

If any provision of this regulation 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.

(Effective July 30, 1992; amended December 1, 2005, November 30, 2009)

Sec. 38a-495a-21. Effective date

This regulation shall be effective on July 30, 1992.

Appendix A

**MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____**

TYPE¹ _____ SMSBP² _____
 For the State of _____
 Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____
 Person Completing This Exhibit _____
 Title _____ Telephone Number _____

line	(a) Earned Premium ³	(b) Incurred 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 Years' Experience)		
4 Refunds Last year (Excluding Interest)		
5 Previous Since Inception (Excluding Interest)		
6 Refunds Since Inception (Excluding Interest)		
7 Benchmark Ratio Since Inception (<i>SEE WORKSHEET FOR RATIO 1</i>)		
8 Experienced Ratio Since Inception		
Total Actual Incurred Claims (line 3, col b) = Ratio 2		
Tot. Earned Prem. (line 3, col a)–Refunds Since Inception (line 6)		
9 Life Years Exposed Since Inception		
If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10 Tolerance Permitted (obtained from credibility table)		

Medicare Supplement Credibility Table

<u>Life Years Exposed Since Inception</u>	<u>Tolerance</u>
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.

- 1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
- 2 "SMSBP" = Standardized Medicare Supplement Benefit Plan
- 3 Includes modal loadings and fees charges.
- 4 Excludes Active Life Reserves.

5 This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

**MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____**

TYPE¹ _____ SMSBP² _____
For the state of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This 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 =
(Tot. Earned Premiums (line 3, col a)–Refunds Since Inception (line 6)) x 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.

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 - Please Type

Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES FOR CALENDAR YEAR _____

TYPE¹ _____ SMSBP² _____
 FOR THE STATE OF _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing This Exhibit _____
 Title _____ Telephone Number _____

(a) ³ Year	(b) ⁴ Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o) ⁵ 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		0.8
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 ⁺⁶		4.175		0.567		8.684		0.838		0.89
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception: $(l + m)/(k + m)$:

¹Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

²For the calendar year on the appropriate line in column (a),

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.)

³These 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.

⁴To include the earned premium for all years prior to as well as the 15th year prior to the current year.

⁵SMSBP^{**} = Standardized Medicare Supplement Benefit Plan. Use "p" for pre-standardized plans

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR _____

TYPE¹ _____ SMSBP² _____
 FOR THE STATE OF _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing This Exhibit _____
 Title _____ Telephone Number _____

(a) ³ Year	(b) ⁴ Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(a) ⁵ Policy Year Loss Ratio
1		2.770	0.442	0.442	0.000	0.000	0.000	0.000		0.4
2		4.175	0.493	0.493		0.000		0.000		0.55
3		4.175	0.493	0.493		1.194		0.659		0.65
4		4.175	0.493	0.493		2.245		0.669		0.67
5		4.175	0.493	0.493		3.170		0.678		0.69
6		4.175	0.493	0.493		3.998		0.686		0.71
7		4.175	0.493	0.493		4.754		0.695		0.73
8		4.175	0.493	0.493		5.445		0.702		0.75
9		4.175	0.493	0.493		6.075		0.708		0.76
10		4.175	0.493	0.493		6.650		0.713		0.76
11		4.175	0.493	0.493		7.176		0.717		0.76
12		4.175	0.493	0.493		7.655		0.720		0.77
13		4.175	0.493	0.493		8.093		0.723		0.77
14		4.175	0.493	0.493		8.493		0.725		0.77
15+ ⁶		4.175	0.493	0.493		8.684		0.725		0.77
Total:		(k):	(l):	(m):	(n):	(m):		(m):		(m):

Benchmark Ratio Since Inception: (l + m)/(k + m):

¹Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

²Year 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.)

³These 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.

⁴They are shown here for informational purposes only.

⁵To include the earned premium for all years prior to as well as the 15th year prior to the current year.

⁶For the calendar year on the appropriate line in column (a),

the premium earned during that year for policies issued in

that year.

²:"SMSBP" = Standardized Medicare Supplement Benefit Plan. Use "p"

for pre-standardized plans

APPENDIX B

**FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES**

Company Name: _____

Address: _____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following on each resident of this state who has in force more than one 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

APPENDIX C

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 prohibits the sale of a health insurance policy (the term policy or policies includes certificates) that duplicate 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 for the policy.

2. All types of health insurance policies that duplicate Medicare shall include one 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 policy.

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 preempt state laws that are more stringent than the federal requirements.

8. The federal law does not preempt existing state form filing requirements.

9. Section 1882 of the Federal Social Security Act was amended in subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should 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
- (outpatient prescription drugs if you are enrolled in Medicare Part D)
- 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 health insurance assistance program (SHIP).

(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
- (outpatient prescription drugs if you are enrolled in Medicare Part D)
- 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 health insurance assistance program (SHIP).

(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 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
- (outpatient prescription drugs if you are enrolled in Medicare Part D)
- 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 health insurance assistance program (SHIP).

(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 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
- (outpatient prescription drugs if you are enrolled in Medicare Part D)
- 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 health insurance assistance program (SHIP).

(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 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

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
- (outpatient prescription drugs if you are enrolled in Medicare Part D)
- 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 health insurance assistance program (SHIP).

(Original disclosure statement for policies that provide benefits upon both an expense-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
- (outpatient prescription drugs if you are enrolled in Medicare Part D)
- 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 health insurance assistance program (SHIP).

(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
- (outpatient prescription drugs if you are enrolled in Medicare Part D)
- 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 health insurance assistance program (SHIP).

(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
- (outpatient prescription drugs if you are enrolled in Medicare Part D)
- 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 health insurance assistance program (SHIP).

(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 from 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
- (outpatient prescription drugs if you are enrolled in Medicare Part D)
- 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 health insurance assistance program (SHIP).

(Alternative 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 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 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
- (outpatient prescription drugs if you are enrolled in Medicare Part D)
- 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 health insurance assistance program (SHIP).

(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 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
- (outpatient prescription drugs if you are enrolled in Medicare Part D)
- 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 health insurance assistance program (SHIP).

(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
- (outpatient prescription drugs if you are enrolled in Medicare Part D)
- 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 health insurance assistance program (SHIP).

(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
- (outpatient prescription drugs if you are enrolled in Medicare Part D)
- 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 health insurance assistance program (SHIP).

(Alternative disclosure statement for other health insurance policies not specifically identified in the previous 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
- (outpatient prescription drugs if you are enrolled in Medicare Part D)
- 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 health insurance assistance program (SHIP).

(Effective July 30, 1992; amended December 1, 2005, November 30, 2009)

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Long-Term Care Insurance

Secs. 38a-501-1—38a-501-7.

Repealed, September 30, 1994.

Individual Long-Term Care Insurance

Sec. 38a-501-8. Applicability and scope

Except as otherwise specifically provided, Sections 38a-501-8 to 38a-501-24, inclusive, apply to all individual long-term care insurance policies delivered or issued for delivery in this state on or after the effective date of this regulation by any insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center.

(Effective September 30, 1994)

Sec. 38a-501-9. Definitions

As used in Sections 38a-501-8 to 38a-501-24, inclusive:

(a) “Long-term care policy” means any individual health insurance policy, or any individual subscriber contract, or any amendment, endorsement or rider to any such policy or subscriber contract delivered or issued for delivery to any resident of this state which is designed to provide benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for at least one year after a reasonable elimination period. A long-term care policy shall provide benefits for confinement in a nursing home or confinement in the insured’s own home or both. Any additional benefits provided shall be related to long-term treatment of an injury, illness or loss of functional capacity. “Long-term care policy” shall not include any such policy, contract or certificate which is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(b) “Applicant” means the person who seeks to contract for insurance benefits.

(Effective September 30, 1994)

Sec. 38a-501-10. Policy definitions and terms

No insurance policy or subscriber contract may be advertised, solicited or issued for delivery to any resident of this state as a long-term care policy unless the terms used in such policy or subscriber contract conform to the meanings given in this section.

(a) “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.

(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) Such definition may be further modified to exclude injuries for which benefits are provided under any workers' compensation, employers' liability or similar law, or the basic reparations benefits of a no-fault motor vehicle insurance plan.

(b) "Activities of daily living" means activities such as, for example, bathing, dressing, eating, toileting, and transferring from bed to chair.

(c) "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.

(d) "Adult day care" shall not be defined more restrictively than a program of services prescribed by a physician and provided by an organization that provides a program of adult day care outside the home which: is licensed in accordance with applicable state laws; has a full-time director; has one or more registered nurses (R.N.s) or licensed practical nurses (L.P.N.s) in attendance during operating hours for at least 4 hours a day; operates at least 5 days a week for a minimum of 6 hours a day; maintains a written record of medical services given to each client; and has established procedures for obtaining appropriate aid in the event of a medical emergency.

(e) "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall be defined in relation to its status, facilities and available services. A definition of such home or facility shall not be more restrictive than one requiring that it: (1) be operated pursuant to law; (2) be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested; (3) be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under supervision of a duly licensed physician; (4) provide continuous twenty-four hours a day nursing service by or under the supervision of a registered nurse (R.N.); and (5) maintains a daily medical record of each patient. The definition of such home or facility may provide that such term shall not be inclusive of: (1) any home, facility or part thereof used primarily for rest; (2) a home or facility for the aged or for the care of drug addicts or alcoholics; or (3) a home or facility primarily used for the care and treatment of mental disease or disorders, or custodial or educational care.

(f) "Custodial care" shall not be defined more restrictively than care which is (1) provided primarily to assist the insured in the activities of daily living; (2) can be provided without professional skills or training; and (3) could not be omitted without adversely affecting the insured's physical or mental condition.

(g) A "custodial or intermediate nursing home" is an institution which: (1) is licensed as a nursing home or operated under the law as a nursing home or a hospice; (2) operates primarily to provide nursing care for which a charge is made for three or more persons; (3) provides continuous nursing care under the supervision of a registered nurse (R.N.), a licensed practical nurse (L.P.N.) or a licensed physician; (4) is not a hospital or clinic; (5) is not a home for the aged or mentally ill, a rest home, a community living center, or a place that provides domiciliary, residency, or retirement care; and (6) is not a facility which operates primarily for the treatment of alcoholics or drug addicts, even if it is a section of a nursing home.

(h) "Home health care services" shall not be defined more restrictively than medical and non-medical services, provided to ill, disabled or infirm persons who reside at home. Such services may include, for example, homemaker/home health aide services, personal care services, adult day care, respite care services and hospice care services.

(i) "Hospice Care" shall not be defined more restrictively than a program that: (1) provides support and care to an insured who is terminally ill, with no reasonable

prospect of cure, and who has a life expectancy of 6 months or less as estimated by a physician; (2) is prescribed by and under the direction of a physician; (3) is provided by an organization that meets applicable federal or state requirements for certification or licensing as a hospice care organization. Hospice Care may be defined to exclude services provided to someone other than the insured.

(j) "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. (1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital: (A) be an institution operated pursuant to law; and (B) be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and (C) provide twenty-four hour nursing service by or under the supervision of registered nurses (R.N.s). (2) The definition of the term "hospital" may state that such term shall not be inclusive of: (A) convalescent homes, convalescent, rest, or nursing facilities; (B) facilities primarily affording custodial, educational or rehabilitative care; (C) facilities for the aged, drug addicts or alcoholics; or (D) any military or veterans' or soldiers' home or any hospital contracted or operated by any national government or agency thereof for the treatment of members or former members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(k) "Loss of Functional Capacity" shall mean that the insured requires care to assist in meeting day-to-day living requirements such as, but not limited to, eating, bathing and dressing.

(l) "Medicare" shall be 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.

(m) "Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neuroses, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, except that Alzheimer's disease shall not be considered a mental or nervous disorder.

(n) "Necessary Care for Confinement in the Insured's Own Home" shall not be defined more restrictively than home health care services provided to an insured who has suffered a loss of functional capacity.

(o) "Necessary Care for Confinement in a Nursing Home" shall not be defined more restrictively than admitted upon recommendation of a physician, other than the proprietor or employee of the skilled nursing care facility, for care which is medically necessary and which is not at first custodial or intermediate in nature but may, after admission, be reduced to a level that is primarily custodial or intermediate.

(p) "One Period of Confinement" means consecutive days of confinement; it shall be deemed to include successive periods of confinement which are due to the same or related cause and are not separated by at least ninety (90) days during which the covered person is not confined whether at home or in an institution for either skilled nursing care, intermediate or custodial care.

(q) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

(r) "Physician" shall be defined as a person who is licensed by the state in which he or she practices to give treatment for which benefits are provided under the policy and who is acting within the scope of his or her license.

(s) "Sickness or Illness" shall not be defined more restrictively than the following: Sickness or illness means disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. The definition may be further modified to exclude diseases for which benefits are provided under any workers' compensation, employers' liability or similar law.

(Effective September 30, 1994)

Sec. 38a-501-11. Minimum standards

No individual insurance policy or subscriber contract shall be advertised, solicited or issued for delivery in this state as a long-term care policy which does not meet the following minimum standards. These are minimum standards and 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 regulation.

(a) **Renewability.** The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 38a-501-13.

(1) No individual long-term care policy shall contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(2) The term "guaranteed renewable" shall be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and 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 cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(3) The term "noncancellable" shall be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(b) A long-term care policy shall not deny a claim for loss which occurs or confinement which begins more than six (6) months from the effective date of the policy for a pre-existing condition. The policy or subscriber contract shall not define a pre-existing 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.

(c) A long-term care policy shall not indemnify against losses resulting from sickness on a different basis from losses resulting from accidents.

(d) **Limitations and Exclusions.** An individual long-term care insurance policy shall not include limitations or exclusions which are more restrictive than the following:

(1) **PRE-EXISTING CONDITIONS LIMITATION** - This policy does not pay benefits for loss which occurs or confinement which begins within six months after the effective date of the policy as a result of a pre-existing condition.

(2) **OTHER EXCLUSIONS** - This policy does not cover: (i) loss which is caused by declared or undeclared war or any act thereof; (ii) loss which is caused by mental disease or disorder without demonstrable organic disease; (iii) loss which is caused by suicide or any attempt thereof (while sane or insane), or intentionally self-inflicted injury; (iv) confinement in a government institution unless a charge is made which the covered person is obligated to pay; (v) confinement due to alcoholism or drug

addiction; (vi) confinement in a hospital; or (vii) confinement or care received outside of the United States.

(3) A policy may provide that its benefits shall not duplicate benefits payable by Medicare.

(e) No long-term care policy shall use waivers to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions.

(f) **Long-term care policies shall make reasonable provision for waiver of premium.** As to benefits for institutional confinement, this requirement is met if the policy provides for a waiver of premium after benefits have been paid for ninety (90) consecutive days and thereafter during the continuance of the consecutive days for which benefits are paid.

(g) Long-term care policies, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy to the insurer or its agent within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason. Long-term care policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the policyholder shall have the right to return the policy to the insurer within thirty (30) days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

(h) Long-term care policies shall not condition benefits upon prior hospitalization or institutionalization.

(i) Long-term care policies shall include a provision which states that upon notification to the company of a person's death, the company will refund on a pro-rata basis any part of a periodic premium paid by that person which applies to the period after death.

(j) Long-term care policies shall not have an elimination period greater than one hundred (100) days of confinement.

(k) Long-term care policies shall include a provision that the policy shall be incontestable, except for nonpayment of premium, after it has been in force for two years from its date of issue.

(l) **Extension of Benefits.** Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

(m) The premiums charged to an insured for long-term care insurance shall not increase due solely to either the increasing age of the insured at ages beyond sixty-five (65) or the duration the insured has been covered under the policy.

(n) The requirement that a long-term care insurance policy provide benefits for at least one year of confinement after a reasonable elimination period shall be met by providing benefits solely for confinement in a nursing home, solely for confinement at home, or for confinement either in a nursing home or at home.

(o) **Payment of Benefits.** A long-term care policy 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.

(p) Long-term care policies which only provide benefits for confinement in the insured’s own home shall include a statement to that effect on the first page of the policy in bold print.

(q) A long-term care insurance policy that provides benefits for home health care, shall not limit or exclude such benefits (1) by requiring that the insured would need skilled care in a skilled nursing facility if home care services were not provided; (2) by requiring that the insured 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 home care worker acting within the scope of his or her licensure or certification; (5) by excluding coverage for personal care services provided by a home health aide; (6) 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; (7) by requiring that the insured have an acute condition before home health care services are covered; (8) by limiting benefits to services provided by Medicare-certified agencies or providers; (9) by excluding coverage for adult day care, hospice care, skilled nursing care, or physical, occupational, respiratory or speech therapy.

(r) The application for every individual long-term care policy shall include a section inviting the applicant to give the name of an individual who is to receive notice of lapse concurrently with any such notice sent to the policyholder. Along with space for the name and address of such individual, this section shall include a notice to the applicant as follows (or in substantially similar language): YOU WILL RECEIVE NOTICE IF YOUR POLICY IS ABOUT TO LAPSE (TERMINATE) BECAUSE YOU HAVE NOT PAID PREMIUMS. WE WILL BE GLAD TO SEND A COPY OF THIS NOTICE TO ANOTHER PERSON, IF YOU WOULD LIKE. THAT PERSON WILL NOT BE RESPONSIBLE FOR PAYMENT OF THE PREMIUM, AND YOU WILL ALWAYS RECEIVE YOUR OWN COPY OF THE NOTICE. IF YOU WANT AN EXTRA COPY SENT TO ANOTHER PERSON, PLEASE GIVE US THAT PERSON’S NAME AND ADDRESS.

(Effective September 30, 1994)

Sec. 38a-501-12. Prohibition against pre-existing conditions and probationary periods in replacement policies

If a long-term care policy replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to pre-existing conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy or certificate.

(Effective September 30, 1994)

Sec. 38a-501-13. Required disclosure provisions

(a) **Renewability.** Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(b) **Riders and Endorsements.** Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured or exercises a specifically

reserved right under a long-term care policy, all riders or endorsements added to a long-term care policy after date of issue or at reinstatement or renewal shall require a signed acceptance by the insured. After date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, except 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, rider or endorsement.

(c) **Limitations.** If a long-term care insurance policy contains any limitation with respect to pre-existing conditions, such limitation shall appear as a separate paragraph of the policy and shall be labeled "PRE-EXISTING CONDITIONS LIMITATION."

(d) **Other Limitations or Conditions on Eligibility for Benefits.** A long-term care insurance policy shall set forth a description of any limitations or conditions for eligibility, including any required number of days of confinement, in a separate paragraph of the policy and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

(Effective September 30, 1994)

Sec. 38a-501-14. Prohibition against post claims underwriting

(a) All applications for long-term care insurance policies 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. 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 shall not be rescinded for that condition.

(c) Except for policies which are guaranteed issue:

(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:

Caution: If your answers on this application are incorrect or untrue, (company) has the right to deny benefits or rescind your policy.

(2) The following language or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy at the time of delivery:

Caution: The issuance of this long-term care insurance policy is based upon your responses to the questions on your application. A copy of your application (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)

(d) A copy of the completed application shall be delivered to the insured no later than at the time of delivery of the policy unless it was retained by the applicant at the time of application.

(e) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy rescissions, both state and countrywide, except those which the insured voluntarily effectuated.

(Effective September 30, 1994)

Sec. 38a-501-15. Filing requirements

(a) All filings of rates and rating schedules shall be accompanied by an actuarial certification demonstrating that expected claims in relation to premiums comply with the loss ratio required by subsection (b) of Section 38a-501 of the General Statutes 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 required loss ratio standard.

(b) Insurers shall submit a description of the method used to determine the standard for the payment of policy benefits with each policy form subject to subsection (o) of Section 38a-501-11 which they file for approval.

(c) Every insurer, fraternal benefit society, hospital service corporation, medical service corporation or health care center providing individual long-term care insurance in this State shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance for review or approval to the extent this may be required in accordance with regulations adopted pursuant to Section 38a-819 of the General Statutes. All such advertisements shall be retained as provided in Section 38a-819-18 of these regulations.

(Effective September 30, 1994)

Sec. 38a-501-16. Standards for marketing

(a) Every insurer, fraternal benefit society, hospital service corporation, medical service corporation or health care center marketing long-term care insurance coverage in this state, directly or through its producers shall:

(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 the following:

“Notice to buyer: This policy 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 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 other entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subsection.

(6) Provide, at solicitation, written notice to the prospective policyholder of the availability of any insurance counselling program that may be provided or approved by any state agency for this purpose, together with the name, address and telephone number of such program.

(b) In addition to the practices prohibited in Sections 38a-815 to 38a-831, inclusive, of the General Statutes 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.

(Effective September 30, 1994)

Sec. 38a-501-17. Suitability of recommended purchase

(a) An agent who recommends the purchase or replacement of a long-term care policy or certificate shall have reasonable grounds for believing that the recommendation is suitable for the applicant upon the basis of the facts, if any, disclosed by the applicant concerning his or her health and financial circumstances.

(b) Before selling any individual long-term care policy, an agent shall make reasonable efforts to obtain information concerning the applicant's health and financial circumstances.

(c) Before issuing any individual long-term care policy, a direct response insurer shall have reasonable grounds for believing that the purchase of such policy, whether or not it involves the replacement of existing coverage, is suitable for the applicant upon the basis of the facts, if any, disclosed by the applicant concerning his or her health and financial circumstances.

(d) Every direct response insurer shall include questions on its applications for long-term care insurance that are reasonably designed to obtain information concerning the applicant's health and financial circumstances.

(Effective September 30, 1994)

Sec. 38a-501-18. Requirement to deliver shopper's guide

A long-term care insurance shopper's guide approved by the Commissioner shall be provided to all prospective applicants for a long-term care insurance policy.

(a) In the case of agent solicitations, an agent shall deliver the shopper's guide prior to the presentation of an application.

(b) In the case of direct response solicitations, the shopper's guide shall be presented in conjunction with any application.

(Effective September 30, 1994)

Sec. 38a-501-19. Requirement to offer a non-forfeiture benefit

No insurer shall offer for sale a long-term care insurance policy unless the insurer also offers the applicant the option to purchase a policy that provides a non-forfeiture benefit. An insurer shall meet this requirement by providing return of premium, full benefits for a reduced benefit period, reduced benefits for the full benefit period, or another benefit that is acceptable to the Commissioner. A policy that provides a non-forfeiture benefit shall include a schedule of this benefit.

(b) If the offer required to be made under subsection(a) of this section is declined by the applicant, the insurer shall provide a contingent benefit upon lapse that shall be available during a period of 120 days following a substantial increase in premium rates.

(c) An insurer shall meet the requirement of a contingent benefit upon lapse by providing return of premium, full benefits for a reduced benefit period, reduced

benefits for the full benefit period, or another benefit that is acceptable to the Commissioner.

(d) A contingent benefit upon lapse shall be triggered each time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the policyholder's initial annual premium described in this subsection, based on the policyholder's age at issue, and where the policy lapses within 120 days of the due date of the premium so increased. Policyholders shall be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

Triggers for a substantial premium increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

On or before the effective date of a substantial premium increase as described in this subsection, the insurer shall:

(1) offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) offer to convert the coverage to paid-up status with a shortened benefit period. With respect to the two offers set forth in subdivisions (1) and (2) of this subsection:

(A) election by the policyholder may be made at any time during the 120 day period following the due date of the increased premium.

(B) The same benefit amounts and frequency in effect at the time of lapse will be payable for a qualifying claim, with a reduction in the lifetime maximum dollars or days under the policy.

(C) The standard non-forfeiture credit for lifetime maximum dollars or days shall be equal to 100% of sum of all premiums paid, including the premiums paid prior to any changes in benefits.

(D) The minimum non-forfeiture credit for lifetime maximum dollars or days shall not be less than thirty times the daily nursing home benefit at the time of lapse; and

(3) notify the policyholder that a default or lapse at any time during the 120-day period following the premium due date shall be deemed to be the election of the offer to convert to a paid-up status with a shortened benefit period unless the option in subsection (e)(3) of this section applies.

(e) A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period each time an insurer increases the premium rates within the fixed or limited premium paying period to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the policyholder's initial annual premium described in this subsection, based on the policyholder's issue age, where there is a lapse of the policy within 120 days of the due date of the premium so increased, and where the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period is forty percent or more. No premium rate increases shall be permitted beyond the fixed or limited premium paying period as the policy is deemed to be fully paid up. Policyholders shall be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by subsection (d) of this section and where both are triggered, the benefit provided shall be at the option of the policyholder.

On or before the effective date of a substantial premium increase as described in this subsection, the insurer shall:

(1) offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased. The policyholder may elect this option at any time during the 120 day period following the due date of the increased premium;

(2) offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent of the amount payable in effect immediately prior to the lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120 day period following the due date of the increased premium; and

(3) notify the policyholder that a default or lapse at any time during the 120 day period following the premium due date shall be deemed to be the election of the offer to convert to a paid-up status described in subsection (e)(2) of this section if the ratio is forty percent or more.

(f) To determine whether contingent non-forfeiture upon lapse provisions are triggered when a replacing insurer purchases or otherwise assumes a block or blocks of long-term care insurance policies from another insurer, the percentage increase shall be calculated based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(g) Contingent benefits are effective when triggered.

(h) The sum of all benefits paid by the insurer while the policy is in premium paying status or while the policy is in paid up status will not exceed the maximum benefits which would be payable if the policy had continued in premium paying status.

(i) The provisions of this section apply to any long term care policy issued in this state on or after the effective date of this regulation.

(Effective September 30, 1994; amended June 24, 2009)

Sec. 38a-501-20. Requirement to offer inflation protection

(a) No insurer shall offer for sale a long-term care insurance policy unless the insurer also offers the applicant the option to purchase a policy that provides for meaningful periodic benefit level increases to account for reasonably anticipated increases in the costs of long-term care services. Insurers shall offer each applicant, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);

(2) Guarantees 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 no less 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; or

(3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(b) 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.

An insurer may use a reasonable graphic demonstration for the purposes of this disclosure.

(c) 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.

(d) 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 the fact that the premium may change in the future unless the premium is guaranteed to remain constant.

(e) Inflation protection as provided in subsection (a) of this section shall be included in a long-term care insurance policy unless the insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection shall be considered 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. Specifically, I have reviewed Plans _____, and I reject inflation protection.

(Effective September 30, 1994)

Sec. 38a-501-21. Standard format outline of coverage

(a) No long-term care policy shall be delivered or issued for delivery to any resident of this state unless an appropriate outline of coverage in the format prescribed herein is completed as to such policy, and is delivered to the applicant at the time application or solicitation is made and acknowledgement of receipt or certification of delivery of such outline of coverage is provided to the insurer. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of such request, shall make such delivery no later than at the time of policy delivery.

(b) The outline of coverage shall be a free standing document, using no smaller than twelve point type.

(c) The outline of coverage shall contain no material of an advertising nature.

(d) 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.

(e) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(f) Format for outline of coverage:

(COMPANY NAME)
(ADDRESS - CITY & STATE)
(TELEPHONE NUMBER)
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE
(Policy Number)

(Except for policies which are guaranteed issue, the following caution statement, or language substantially similar, shall appear as follows in the outline of coverage.)

Caution: The issuance of this long-term care insurance policy is based upon your responses to the questions on your application. A copy of your application (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 which was issued in Connecticut.

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 policy contains governing contractual provisions. This means that the 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 CAREFULLY!**

3. **TERMS UNDER WHICH THE POLICY 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 contains provisions providing for a refund or partial refund of premium upon the death of an insured and does or does not contain provisions providing for such a refund upon surrender of the policy. Include a description of all such refund provisions.)

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 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 level of care provided.)

(c) (Non-institutional benefits, by level of care provided.)

(An explanation of any qualifying criteria used to determine an insured's eligibility for benefits shall accompany each benefit description. If an attending physician or other specified person must certify to a loss of functional capacity in order for the insured to be eligible for benefits, this shall be specified. If activities of daily living (ADLs) are used to determine an insured's eligibility for benefits then these shall be explained.)

7. **LIMITATIONS AND EXCLUSIONS**

(Describe:

(a) Any pre-existing conditions provision;

(b) Non-eligible facilities/providers (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(c) Non-eligible levels of care;

(d) Exclusions/exceptions;

(e) Other 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 provision;
- (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, indicate 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, indicate whether there will be any additional premium charge imposed, and describe how that is to be calculated.)

9. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED.

- (a) (Describe policy renewability provisions);
- (b) (Describe waiver of premium provisions, including whether the insured is entitled to a refund of unearned premium in the event of a waiver);
- (c) (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 any qualifying criteria that determines such an insured's eligibility for policy benefits.)

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 whether medical underwriting is used;
- (b) Describe other important features.)

(Effective September 30, 1994)

Sec. 38a-501-22. Replacement

(a) 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 or certificate in force or whether a long-term care policy is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. 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.

(1) Do you have another long-term care insurance policy or certificate in force (including a 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, with which company? 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?

(b) Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five (5) years which are no longer in force.

(c) **Solicitations Other than Direct Response.** 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 individual long term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One 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 an individual long-term care insurance policy to be issued by (company name) Insurance Company. 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 coverage only if, after due consideration, you find that purchase of this long-term care policy 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 (pre-existing 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 may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing 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) _____

(d) **Direct Response Solicitations.** 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. 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 delivered herewith issued by (company name) Insurance Company. 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.

1. Health conditions which you may presently have (pre-existing 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 may not contain new pre-existing conditions or probationary periods. Your insurer will waive any time periods applicable to pre-existing 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) _____

(e) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy 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 is issued, whichever is sooner.

(Effective September 30, 1994)

Sec. 38a-501-23. Reporting requirements

(a) Every insurer shall report annually by June 30 the number of policies lapsed in the previous calendar year, the average total number of policies in force during the preceding calendar year, and the resulting ratio.

(b) Every insurer shall report annually by June 30 the number of replacement policies sold in the previous calendar year, the total number of policies sold during the preceding calendar year, and the resulting ratio.

(c) Every insurer shall report annually by June 30 the number of replacement policies sold in the previous calendar year, the average total number of policies in force during the preceding calendar year, and the resulting ratio.

(d) Every insurer shall report annually by June 30 the number of rescissions of policies, except those voluntarily effectuated by an insured, in the previous calendar year.

(e) For purposes of this section, “policies” shall mean only individual long-term care insurance policies and “report” shall mean on a statewide and national basis.
(Effective September 30, 1994)

Sec. 38a-501-24. Effective date; separability

(a) The effective date of Sections 38a-501-8 to 38a-501-24, inclusive, shall be September 30, 1994.

(b) If any provision of Sections 38a-501-8 to 38a-501-24, inclusive, or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of these regulations and the application of such provision to other persons or circumstances shall not be affected thereby.

(Effective September 30, 1994)

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Cancer Clinical Trials

Repealed 38a-504a-1—38a-504a-2
Request for authorization of coverage 38a-504a-3

Clinical Trials

Secs. 38a-504a-1—38a-504a-2.

Repealed, July 2, 2012.

Sec. 38a-504a-3. Request for authorization of coverage

Standardized form to request authorization for coverage of routine patient care costs associated with clinical trials required by sections 38a-504f and 38a-542f of the Connecticut General Statutes. The commissioner may request additional information on the standardized form.

Section I

Date: _____

Member name: _____

Member ID #: _____

Member Date of Birth: _____

Health Insurer: _____

Treating Physician: _____

Contact Person for Additional Information Regarding Member’s Treatment:

Name: _____

Address: _____

Phone number: _____

Fax number: _____

E-mail address: _____

Service requested is: Outpatient Inpatient Office Setting

If outpatient or inpatient is checked:

Facility name & address: _____

Clinical Cooperative Group Number: _____

(Please provide Web site address or other reference for accessing information about this trial.)

Please Note: You may be asked to provide additional information about the clinical trial or the member’s diagnosis and condition prior to the authorization of this request.

If the clinical cooperative group number is provided above, you do not need to complete Section II.

Section II must be completed only if the Clinical Cooperative Group Number is unavailable.

Section II

Diagnosis code: _____

Proposed treatment protocol: _____

Phase of clinical trial: ___ I ___ II ___ III

Sponsor of clinical trial: _____

Clinical Trial has been reviewed and approved by:

- ___ National Institutes of Health
- ___ National Cancer Institute
- ___ Federal Food and Drug Administration
- ___ Federal Dept. of Defense
- ___ Federal Dept. of Veterans Affairs
- ___ Medicare Clinical Trial Policy

Check one: ___ Single center study ___ Multiple center study

List name(s) and address(es) of center(s):

(Adopted effective August 30, 2004; amended March 4, 2009, July 2, 2012)

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Minimum Standards**

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Individual Accident and Sickness Insurance Minimum Standards

Sec. 38a-505-1. Purpose

The purpose of this regulation is to implement Section 38a-505 of the Connecticut General Statutes so as to provide reasonable standardization and simplification of terms and coverages of individual accident and sickness insurance policies and fraternal benefit society certificates in order to facilitate public understanding and comparison and to eliminate provisions contained in individual accident and sickness insurance policies which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims and to provide for full disclosure in the sale of such coverages.

(Effective September 25, 1992)

Sec. 38a-505-2. Authority

This regulation is issued pursuant to the authority vested in the Commissioner under Section 38a-505 of the Connecticut General Statutes.

(Effective September 25, 1992)

Sec. 38a-505-3. Applicability and scope

This regulation shall apply to all individual accident and sickness insurance policies and fraternal benefit society certificates delivered or issued for delivery in this State on and after the effective date hereof; except, it shall not apply to individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this regulation, nor to policies being issued to employees or members as additions to franchise plans in existence on the effective date of this regulation. The requirements contained in this regulation shall be in addition to any other applicable regulations or bulletins previously adopted and not inconsistent therewith.

(Effective September 25, 1992)

Sec. 38a-505-4. Effective date

This regulation shall be effective on January 1, 1979 or 180 days after the date of adoption of the regulation, whichever is later, and shall be applicable to all individual accident and sickness insurance policies and fraternal benefit society certificates delivered or issued for delivery in this State on and after such date which are not specifically exempt from this regulation.

(Effective September 25, 1992)

Sec. 38a-505-5. Policy definitions

Except as provided hereafter, no individual accident or sickness insurance policy or fraternal benefit society certificate delivered or issued for delivery to any person in this State shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this section.

(A) "One Period of Confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharged from and readmission to the hospital occurs within a period of time not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

(B) "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.

(1) The definition of the term “hospital” shall not be more restrictive than one requiring that the hospital:

(a) Be an institution operated pursuant to law; and

(b) Be primarily and continuously engaged in providing or operating either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

(c) Provide 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.’s).

(2) The definition of the term “hospital” may state that such term shall not be inclusive of:

(a) Convalescent homes, convalescent, rest, or nursing facilities; or

(b) Facilities primarily affording custodial, educational or rehabilitory care; or

(c) Facilities for the aged, drug addicts or alcoholics; or

(d) Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the Armed Forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(C) “Convalescent Nursing Home,” “Extended Care Facility,” or “Skilled Nursing Facility” shall be defined in relation to its status, facilities, and available services.

(1) A definition of such home or facility shall not be more restrictive than one requiring that it:

(a) Be operated pursuant to law;

(b) Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

(c) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(d) Provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.);

(e) Maintains a daily medical record of each patient.

(2) The definition of such home or facility may provide that such term shall not be inclusive of:

(a) Any home, facility or part thereof used primarily for rest;

(b) A home or facility for the aged or for the care of drug addicts or alcoholics; or

(c) A home or facility primarily used for the care and treatment of mental diseases or disorders or custodial or educational care.

(D) “Accident,” “Accidental Injury,” “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. The definition shall not be more restrictive than the following; Injury or injuries, for which benefits are provided, means accidental bodily injuries sustained by the insured person which are the direct cause, independent of disease or bodily infirmity or any other cause and occur while the insurance is in force. Such definition may provide that injuries shall not include injuries for which benefits are provided under any workmen’s compensation, employers liability or similar law, the basic reparations benefits of any motor vehicle no-fault plan or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

(E) "Sickness" shall not be defined to be more restrictive than the following: Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period which will not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workmen's compensation, occupational disease, employer's liability or similar law.

(F) "Pre-existing condition shall not be defined to be more restrictive than the following: Pre-existing condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a five (5) year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a five (5) year period preceding the effective date of the coverage of the insured person. This definition does not prohibit an insurer, using an application form designated to elicit the complete health history of a prospective insured and on the basis of the answers on that application, from underwriting in accordance with that insurer's established standards. It is assumed that an insurer that elicits a complete health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition, the policy will be endorsed or amended by including the specific exclusion. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers which elect to use simplified application forms containing questions relating to the prospective insured's health. This definition does, however, prohibit an insurer that elects to use a simplified application, with or without a question as to the applicant's health at the time of application, from reducing or denying a claim on the basis of the existence of a pre-existing condition that is defined more restrictively than above.

(G) "Physician" shall be defined as a person who is licensed by the State in which he or she practices to give treatment for which benefits are provided under the policy and who is acting within the scope of his or her license.

(H) "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the State.

(I) "Total Disability." (1) A general definition of total disability cannot be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation for which he is or becomes qualified by reason of education, training or experience and not, in fact, engaged in any employment or occupation for wage or profit.

(2) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

(a) Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation," or

(b) Engage in any training or rehabilitation program.

(3) An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his regular occupation or

words of similar import. An insurer may require care by a physician (other than the insured or a member of the insured's immediate family).

(J) "Partial Disability" shall be defined in relation to the individual's inability to perform one or more, but not all, of the "major," "important," or "essential" duties of his employment or occupation or may be related to a "percentage" of time worked or to a "specified number of hours" or to "compensation." Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

(K) "Residual Disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important," or essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy which provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import which in the opinion of the commissioner adequately and fairly describes the benefit.

(L) "Medicare" shall be defined in any hospital, surgical or medical expense policy which relates its coverage to eligibility for Medicare or Medicare benefits. 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.

(M) "Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(Effective September 25, 1992)

Sec. 38a-505-6. Separability

If any provision of this regulation (Secs. 38a-505-1—38a-505-5) 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.

(Effective September 25, 1992)

Sec. 38a-505-7. Prohibited policy provisions

(A) Except as provided in Section 38a-505-5(E), no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy subject to the further exception that a policy may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproductive organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six (6) months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

(B) No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such

dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than six (6) months. The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that such renewal is optional with the policyholder.

(C) No policy shall exclude coverage for a loss due to a pre-existing condition for a period greater than twelve (12) months following policy issue where the application for such insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and such pre-existing condition is not specifically excluded by the terms of the policy.

(D) A disability income policy may contain a "return of premium" or "cash value benefit" so long as:

(1) The insurance policy is non-cancellable or, if the benefit is added by rider, it is attached to a non-cancellable policy.

(2) The forms provide for the payment of surrender value upon (a) the written request of the insured, and surrender of the policy, (b) lapse of the policy, (c) death of the insured, or (d) on the termination date of the contract.

(3) The surrender value is based on policy duration, premiums paid by the insured and benefits paid by the company. A refund is available after a policy has been in force a minimum of three years (two years on policies issued on ages 46-50).

(4) The form is not issued beyond age 50.

(5) The insurer includes a detailed statement of the method of computing the premium rates, the tables of cash value, and the estimated loss ratio.

(6) The insurer includes a demonstration of the fiscal integrity of the product and the company.

(7) The form is not on the basis of the 10 year roll-over concept.

(E) No other policy shall provide a return of premium or cash value benefit, except returned or unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

(F) Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the Federal Government.

(G) No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition except as follows:

(1) Pre-existing conditions or diseases, except for congenital anomalies of a covered dependent child;

(2) Mental or emotional disorders, alcoholism and drug addiction except as set forth in section 38a-488a of the Connecticut General Statutes;

(3) Pregnancy, except for complications of pregnancy, other than for policies defined in section 38a-505-9(F) of the Regulations of Connecticut State Agencies;

(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the Armed Forces or units auxiliary thereto;

(b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury except with respect to individual health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the Connecticut General Statutes;

(c) Aviation;

(d) With respect to short-term renewable policies, inter-scholastic sports;

(5) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting

from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;

(6) Treatment provided in a government hospital, benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employers liability or occupational disease law, or the basic reparations benefits of any motor vehicle no-fault law, services rendered by employees of hospitals, laboratories or other institutions, services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

(7) Dental care or treatment except as set forth in sections 38a-491, 38a-491a, and 38a-491b, inclusive, of the Connecticut General Statutes;

(8) Eye glasses, hearing aids and examination for the prescription or fitting thereof except as set forth in section 38a-490b of the Connecticut General Statutes;

(9) Rest cures, custodial care, transportation and routine physical examinations; and

(10) Territorial limitations.

(H) Other provisions of this regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page of the policy or unless notice of the waiver appears on the first page or specification page.

(I) Policy provisions precluded in this Section shall not be construed as a limitation on the authority of the Commissioner to disapprove other policy provisions in accordance with Section 38a-481 of the Connecticut General Statutes which, in the opinion of the Commissioner, are unjust, unfair, or deceptive, or unfairly discriminatory to the policyholder, beneficiary, or any person insured under the policy or which encourage misrepresentation of the policy.

(Effective September 25, 1992; amended August 30, 2004)

Sec. 38a-505-8. Separability

If any provision of this regulation (Sec. 38a-505-7) 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.

(Effective September 25, 1992)

Sec. 38a-505-9. Accident and sickness minimum standards for benefits

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. No individual policy of accident and sickness insurance or fraternal benefit society certificate shall be delivered or issued for delivery in this State which does not meet the required minimum standards for the specified categories unless the Commissioner finds that such policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the appropriate outline in Section 38a-505-10 (K). Nothing in this section shall preclude the issuance of any policy or contract combining two or more categories of coverage such as hospital expense coverage and medical-surgical expense coverage.

(A) **General Rules.** (1) A "non-cancellable," "guaranteed renewable," or "non-cancellable and guaranteed renewable" policy shall not provide for termination of

coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than non-payment of premium. The policy shall provide that in the event of the insured's death the spouse of the insured, if covered under the policy, shall become the insured.

(2) The terms "non-cancellable," "guaranteed renewable," or "non-cancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section 38a-505-10 (A) (1). 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 until the age of sixty-five (65) or to eligibility for Medicare, 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; provided, however, any accident and health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively or regularly employed. 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 until the age of sixty-five (65) or to eligibility for Medicare, 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 as mandated by statute and except that the insurer may make changes in premium rates by classes; provided, however, any accident and health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed.

(3) In a family policy covering both husband and wife, the age of the younger spouse must be used as the basis for meeting the age and durational requirements of the definitions of "non-cancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in said definition.

(4) When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under such coverage and not just the principal insured.

(5) If a policy contains a status type military service exclusion or a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rata basis.

(6) In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

(7) Policies providing convalescent or extended care benefit following hospitalization shall not condition such benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.

(8) Family coverage shall continue for any dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap on the date that such child's coverage would otherwise terminate under the policy due to the attainment of a specified age limit for children and is chiefly dependent on the insured for support and maintenance. The policy may require that within 31 days of such date the company receive due proof of such incapacity in order for the insured to elect to continue the policy in force with respect to such child, or that a separate converted policy be issued at the option of the insured or policyholder.

(9) Any policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

(10) A policy may contain a provision relating to recurrent disabilities, provided, however, that no such provision shall specify that a recurrent disability be separated by a period greater than six (6) months.

(11) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

(12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(13) Any accident only policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable which are lesser than the maximum amount payable under the policy.

(14) All Medicare supplement policies providing in-hospital benefits only shall include in their provided benefits the initial Part A Medicare deductible as established from time to time by the Social Security Administration.

(15) Termination of the policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period 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 payment of the maximum benefits.

(B) **Basic Hospital Expense Coverage**—“Basic Hospital Expense Coverage” is a policy of accident and sickness insurance which provides coverage for a period of not less than thirty-one (31) days during any one period of confinement for each person insured under the policy for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

(1) Daily hospital room and board in an amount not less than the lesser of (a) 80% of the charges for semi-private room accommodations, or (b) \$30.00 per day;

(2) Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either 80% of the charges incurred up to at least \$1,000.00 or ten times the daily hospital room and board benefits; and

(3) Hospital outpatient services consisting of (a) hospital services on the day surgery is performed, and (b) hospital services rendered within seventy-two (72) hours after accidental injury, in an amount not less than \$50.00, and (c) X-ray laboratory tests to the extent that benefits for such services would have been provided to an extent not less than \$100.00 if rendered to an in-patient of the hospital.

(4) Benefits provided under (1) and (2) above may be provided subject to a combined deductible amount not in excess of \$100.00.

(C) **Basic Medical-Surgical Expense Coverage**—“Basic Medical-Surgical Expense Coverage” is a policy of accident and sickness insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

(1) Surgical services: (a) In amounts not less than those provided on a fee schedule based on an acceptable relative value scale of surgical procedures, such as the 1964 California Relative Value Schedule, up to a maximum of at least \$500.00 for any one procedure; or

(b) Not less than 80% of the reasonable charges.

(2) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or his assistant) performing the surgical service:

(a) In an amount not less than 80% of the reasonable charges; or

(b) 15% of the surgical service benefit.

(3) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than 80% of the reasonable charges; or \$5.00 per day for not less than twenty-one (21) days during one period of confinement.

(D) **Hospital Confinement Indemnity Coverage**—“Hospital Confinement Indemnity Coverage” is a policy of accident and sickness insurance which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than \$30.00 per day and not less than thirty-one (31) days during any one period of confinement for each person insured under the policy.

(E) **Major Medical Expense Coverage**—“Major medical expense coverage” is an accident and sickness insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than \$10,000.00; copayment by the covered person not to exceed 25% of covered charges; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed 5% of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case such deductible may be increased by the amount of the benefits provided by such underlying insurance, for each covered person for at least:

(1) Daily hospital room and board expenses, prior to application of the copayment percentage, for not less than \$50.00 daily (or in lieu thereof the average daily cost of semi-private room rate in the area where the insured resides) for a period of not less than 31 days during continuous hospital confinement;

(2) Miscellaneous hospital services, prior to application of the copayment percentage, for an aggregate maximum of not less than \$1,500 or 15 times the daily room and board rate if specified in dollar amounts;

(3) Surgical services, prior to application of the copayment percentage, to a maximum of not less than \$600 for the most severe operations with the amounts provided for other operations reasonably related to such maximum amount;

(4) Anesthesia services, prior to application of the copayment percentage, for a maximum of not less than 15 percent of the covered surgical fees or alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule;

(5) In-hospital medical services, prior to the application of the copayment percentage, as defined in subdivision (C) (3) of Section 38a-505-9;

(6) Out-of-hospital care, prior to application of the copayment percentage, consisting of physician's services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury; and diagnostic X-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(7) Not fewer than three of the following additional benefits, prior to application of the copayment percentage, for an aggregate maximum of such covered charges of not less than \$1,000;

(a) In-hospital private duty graduate registered nurse services;

(b) Convalescent nursing home care;

(c) Diagnosis and treatment by a radiologist or physiotherapist;

(d) Rental of special medical equipment, as defined by the insurer in the policy;

(e) Artificial limbs or eyes, casts, splints, trusses or braces;

(f) Treatment for functional nervous disorders, and mental and emotional disorders;

(g) Out-of-hospital prescription drugs and medications.

(F) **Disability Income Protection Coverage**—“Disability income protection coverage” is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which:

(1) Provides that periodic payments which are payable at ages after 62 and reduced solely on the basis of age are at least 50% of amounts payable immediately prior to 62.

(2) Contains an elimination period no greater than:

(a) Ninety (90) days in the case of a coverage providing a benefit period of one (1) year or less;

(b) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two years, or

(c) Three hundred and sixty-five (365) days in all other cases during the continuance of disability resulting from sickness or injury.

(3) Has a maximum period of time for which it is payable during disability of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth, or miscarriage in which case the period for such disability may be one (1) month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period. Section 38a-505-9 (F) does not apply to those policies providing business buyout coverage.

(G) **Accident Only Coverage**—“Accident only coverage” is a policy of accident insurance which provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least \$1,000.00 and a single demberment amount shall be at least \$500.00.

(H) **“Specified Accident Coverage”** is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than \$1,000.00 for accidental death; \$1,000.00 for double dismemberment and \$500.00 for single dismemberment.

(I) **“Limited Benefit Health Insurance Coverage”** is any policy or contract which provides benefits that are less than the minimum standards for benefits required under Sections 38a-505-7 (B), (C), (D), (E), (F), (G) and (H). Such policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section 38a-505-10 (K) is completed and delivered as required by Section 38a-505-10 (B).

(Effective September 25, 1992)

Sec. 38a-505-10. Required disclosure provisions

(A) **General Rules.** (1) Each individual policy of accident and sickness insurance or fraternal benefit society certificate shall include a renewal, continuation, or non-renewal provision. The language or specifications of such provision must be consistent with the type of contract to be issued. Such 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 for which it may be renewed.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a 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 policyholder. After date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increase benefit or coverage is required by law.

(3) 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.

(4) A policy 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.

(5) If a policy contains any limitations with respect to pre-existing conditions, such limitations must appear as a separate paragraph of the policy and be labeled as “Pre-existing Conditions Limitations.”

(6) All accident only policies shall contain a prominent statement on the first page of the policy or attached thereto in either contrasting color or in boldface type at least equal to the size of type used for policy captions, a prominent statement as follows: “This is an accident only policy and it does not pay benefits for loss from sickness.”

(7) All policies, except single premium non-renewable policies, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

(8) If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the outline of coverage.

(9) If a policy contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be “Conversion Privilege” or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on

the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

(B) **Outline of Coverage Requirements for Individual Coverages**—No individual accident and sickness insurance policy or fraternal benefit society certificate subject to this regulation shall be delivered or issued for delivery in this State unless an appropriate outline of coverage as prescribed in Sections 38a-505-10 (C) through 38a-505-10 (K) is completed as to such policy or contract; and

(1) Is either delivered with the policy; or

(2) Delivered to the applicant at the time application is made and acknowledgement of receipt or certification of delivery of such outline of coverage is provided to the insurer.

If an outline of coverage was delivered at the time of application and the policy or contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or contract must accompany the policy or contract when it is delivered and contain the following statement, in no less than twelve (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.”

The appropriate outline of coverage for policies or contracts providing hospital coverage which only meets the standards of Section 38a-505-9 (B) shall be that statement contained in Section 38a-505-10 (C). The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 38a-505-9 (B) and 38a-505-10 (C) shall be the statement contained in Section 38a-505-9 (E). The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 38a-505-9 (B) and 38a-505-9 (E) or Sections 38a-505-9 (C) and 38a-505-9 (E) or Sections 38a-505-9 (B), 38a-505-9 (C) and 38a-505-9 (E) shall be the statement contained in Section 38a-505-10 (C).

In any other case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or contract, an alternate outline of coverage may be submitted to the Commissioner for prior approval.

(C) **Basic Hospital Expense Coverage** (Outline of Coverage)—An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 38a-505-9 (B). The items included in the outline of coverage *must appear in the sequence prescribed*.

(Company Name)
Basic Hospital Expense Coverage
Outline of Coverage

(1) **Read Your Policy Carefully**—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **Basic Hospital Expense Coverage**—Policies of this category are designed to provide to persons insured coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, and hospital outpatient services, subject to

any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for physician's or surgeon's fees or *unlimited* hospital expenses.

(3) (A brief *specific* description of the benefits, including dollar amounts and number of days duration where applicable, contained in *this policy*, in the following order:

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Hospital outpatient services; and
- (d) Other benefits, if any.

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(D) **Basic Medical-Surgical Expense Coverage** (Outline of Coverage)—An outline of coverage in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 38a-505-9 (C). The items included in the outline of coverage *must appear in the sequence prescribed*.

(Company Name)
Basic Medical-Surgical Expense Coverage
Outline of Coverage

(1) **Read Your Policy Carefully**—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) **Basic Medical-Surgical Expense Coverage**—Policies of this category are designed to provide to persons insured coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for hospital expenses or *unlimited* medical-surgical expenses.

(3) (A brief *specific* description of the benefits, including dollar amounts and number of days duration where applicable, contained in *this policy*, in the following order:

- (a) Surgical services;
- (b) Anesthesia services;
- (c) In-hospital medical services; and
- (d) Other benefits, if any.

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(E) **Basic Hospital and Medical Surgical Expense Coverage (Outline of Coverage)**—An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Sections 38a-505-9 (B) and 38a-505-9 (C). The items included in the outline of coverage *must appear in the sequence prescribed*.

(Company Name)
Basic Hospital and Medical Surgical Expense Coverage
Outline of Coverage

(1) **Read Your Policy Carefully**—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) **Basic Hospital and Medical Surgical Expense Coverage**—Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital out-patient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for *unlimited* hospital or medical-surgical expenses.

(3) (A brief *specific* description of the benefits, including dollar amounts and number of days duration where applicable, contained in *this policy*, in the following order:

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Hospital outpatient services;
- (d) Surgical services;
- (e) Anesthesia services;
- (f) In-hospital medical services; and
- (g) Other benefits, if any.

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability of continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(F) **Hospital Confinement Indemnity Coverage (Outline of Coverage)**—An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 38a-505-9 (D). The items included in the outline of coverage *must appear in the sequence prescribed*.

(Company Name)
Hospital Confinement Indemnity Coverage
Outline of Coverage

(1) **Read Your Policy Carefully**—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **Hospital Confinement Indemnity Coverage**—Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefits described below.

(3) (A brief *specific* description of the benefits contained in *this policy*, in the following order:

- (a) Daily benefit payable during hospital confinement; and
- (b) Duration of benefit described in (a).

*NOTE: The above description of benefits shall be stated clearly and concisely.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(6) Any benefits provided in addition to the daily hospital benefit.

(G) **Major Medical Expense Coverage** (Outline of Coverage)—An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 38a-505-9 (E). The items included in the outline of coverage *must appear in the sequence prescribed*.

(Company Name)
Major Medical Expense Coverage
Outline of Coverage

(1) **Read Your Policy Carefully**—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **Major Medical Expense Coverage**—Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy. *Basic* hospital or *basic* medical insurance coverage is not provided.

(3) (A brief *specific* description of the benefits, including dollar amounts, contained in *this policy*, in the following order:

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Surgical services;
- (d) Anesthesia services;
- (e) In-hospital medical services;
- (f) Out-of-hospital care;

- (g) Maximum dollar amount for covered charges; and
- (h) Other benefits, if any.

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(H) **Disability Income Protection Coverage** (Outline of Coverage)—An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 38a-505-9 (F). The items included in the outline of coverage *must appear in the sequence prescribed.*

(Company Name)
 Disability Income Protection Coverage
 Outline of Coverage

(1) **Read Your Policy Carefully**—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) **Disability Income Protection Coverage**—Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses.

(3) (A brief *specific* description of the benefits contained in *this policy*:

*NOTE: The above description of benefits shall be stated clearly and concisely.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(I) **Accident Only Coverage** (Outline of Coverage)—An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 38a-505-9 (G). The items included in the outline of coverage *must appear in the sequence prescribed.*

(Company Name)
 Accident Only Coverage
 Outline of Coverage

(1) **Read Your Policy Carefully**—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) **Accident Only Coverage**—Policies of this category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident

ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses.

(3) (A brief *specific* description of the benefits contained in *this policy*:

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (A) (13) of Section 38a-505-9.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(J) **Specified Accident Coverage** (Outline of Coverage)—An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 38a-505-9 (H). The items included in the outline of coverage *must appear in the sequence prescribed*.

(Company Name)
Specified Accident Coverage
Outline of Coverage

(1) **Read Your Policy Carefully**—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **Specified Accident Coverage**—Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits *ONLY* when certain losses occur as a result of specified accidents. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expense.

(3) (A brief *specific* description of the benefits, including dollar amounts, contained in *this policy*:

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (A) (13) of Section 38a-505-9.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(K) **Limited Benefit Health Coverage** (Outline of Coverage)—An outline of coverage, in the form prescribed below, shall be issued in connection with policies which do not meet the minimum standards of Section 38a-505-9 (B), (C), (D), (E), (F), (G) and (H). The items included in the outline of coverage *must appear in the sequence prescribed*.

(Company Name)
Limited Benefit Health Coverage
Outline of Coverage

(1) **Read Your Policy Carefully**—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **Limited Benefit Health Coverage**—Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

(3) (A brief *specific* description of the benefits, including dollar amounts, contained in *this policy*:

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (A) (13) of Section 38a-505-9.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)
(Effective September 25, 1992)

Sec. 38a-505-11. Requirements for replacement

(A) Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(B) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in (C) below. 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. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in (D) below. In no event, however, will such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

(C) The notice required by (B) above for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (Company Name) Insurance Company. 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.

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) 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 interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) 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, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

(date)

(applicant's signature)

(D) The notice required by (B) above for a direct response insurer shall be as follows:

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to (your application) (information you have furnished) you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by (Company Name) Insurance Company. Your new policy provides 10 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.

(1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) 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 interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) (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 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

Sec. 38a-505-12. Separability

If any provision of this regulation (Secs. 38a-505-9—38a-505-11) 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.

(Effective September 25, 1992)

Sec. 38a-505-13. Specified disease policies

(a) A “specified disease policy” means an individual health insurance policy delivered or issued for delivery in this state which pays benefits for the diagnosis or treatment of one or more specifically named diseases, conditions or syndromes in accordance with section 38a-505-13 (c) of the Regulations of Connecticut State Agencies. As used in this section, “condition” includes specifically named diseases, conditions or syndromes unless the context otherwise requires. Any specified disease policy shall meet the general requirements in subsection (b) of this section and the minimum benefit standards pursuant to subsection (c) of this section.

(b) General Requirements:

The following requirements shall apply to specified disease policies in addition to all other requirements applicable to individual accident and sickness policies.

(1) Policies covering a single specified condition or combination of specified conditions may not be sold or offered for sale other than as specified disease policies.

(2) Any policy issued pursuant to this section which conditions payment upon pathological diagnosis of a covered condition, shall also provide that if such a pathological diagnosis is medically inappropriate, a clinical diagnosis shall be accepted in lieu thereof.

(3) Notwithstanding any other provision of this section, specified disease policies described in Section 38a-505-13 (c)(1) and Section 38a-505-13 (c)(2) of the Regulations of Connecticut State Agencies shall provide benefits to any covered person not only for a specified condition but also for any other condition directly caused or aggravated by the specified condition or its treatment.

(4) Specified disease policies shall be at least guaranteed renewable.

(5) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. Premiums paid shall be refunded if the insured is diagnosed with a covered condition during the waiting or probationary period.

(6) Payment of benefits may be conditioned upon a covered person receiving medically necessary care or treatment.

(7) Any application for a specified disease policy shall contain a prominent statement above the signature of the applicant that a person who is already covered by Medicaid should not purchase this coverage. Such statement shall be in bold face type or contrasting color.

(8) The benefits of a specified disease policy shall be paid regardless of other coverage.

(9) Benefit payments under specified disease policies described in Section 38a-505-13 (c)(1) and Section 38a-505-13 (c)(2) of the Regulations of Connecticut State Agencies shall begin with the first day of care or confinement after the effective date of the policy if such care or confinement is for a covered condition even though the diagnosis of a covered condition is made at some later date (but not retroactive more than ninety (90) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of such covered condition.

(10) Specified disease policies shall provide a thirty (30) day free look. Notice of the thirty (30) day free look shall appear on the face page of the policy in bold face equal to at least fourteen (14) point type.

(11) Specified disease policies shall contain a prominent statement on the first page of the policy in bold face type at least equal to fourteen (14) point type as follows: “CAUTION” This policy provides limited coverage. It is not a major medical policy. Read it carefully. It only pays benefits for treatment (or diagnosis) of (specified disease).

(12) The premiums for a policy shall be reasonable in relation to benefits and shall not be excessive or inadequate. The insurer shall establish premiums for specified disease policies in accordance with generally accepted actuarial principles and practices so as to return to policyholders in the form of aggregate benefits provided under the policy during the period for which rates are computed at least sixty-five per cent (65%) of the aggregate premiums earned. The insurer may also charge an annual policy fee of up to thirty dollars (\$30.00), which fee shall be excluded from premium for the purposes of the sixty-five per cent (65%) calculation. Each insurer shall annually report by June 30 earned premiums and incurred claims for the prior calendar year for each approved specified disease policy form in a format acceptable to the insurance commissioner.

(13) “Preexisting condition” shall not be defined to be more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by a physician or received from a physician within a twelve (12) month period preceding the effective date of the coverage of the insured person. No policy shall exclude for a loss due to a preexisting condition for a period greater than twelve (12) months following policy issue.

(c) Each specified disease policy shall meet the minimum benefit standards provided in subdivision (1), (2) or (3) of this subsection. In addition, a specified disease policy may combine coverages of the types described in subdivisions (1), (2), and (3) of this subsection. A policy that combines coverages and meets the minimum benefit standard requirements set forth in subdivision (1), (2), or (3) of this subsection may be approved for sale in the state if it includes some, but not all, of the benefits otherwise permitted by another type of specified disease policy, except that policies combining coverage of the types described in subdivisions (1) and (2) of this subsection shall meet the minimum requirements for each type of coverage.

(1) Coverage for medical expenses incurred by each person insured under the policy for one or more specifically named diseases, conditions or syndromes, with a deductible amount not in excess of one thousand dollars (\$1,000), co-insurance by the insured not to exceed twenty five per cent (25%), and an overall aggregate lifetime benefit limit, per person, of not less than two hundred and fifty thousand dollars (\$250,000). Any inside limits shall be reasonable. Policy benefits shall include:

- (A) Hospital room and board and hospital furnished medical services or supplies;
- (B) Treatment by, or under the direction of, a physician or surgeon;
- (C) Private duty services of a registered nurse (R.N.) or a Licensed Practical Nurse (L.P.N.);
- (D) X-ray, radium, cobalt, nuclear medicine, chemotherapy, and other therapeutic procedures used in diagnosis and treatment;
- (E) Licensed ambulance for local service to or from a local hospital;
- (F) Blood transfusions, and plasma, and the administration thereof;

(G) Drugs and medicines prescribed by a physician;

(H) The rental of any respirator or other mechanical apparatus;

(I) Braces, crutches, wheelchairs and other adaptive devices deemed necessary by the attending physician because of the incapacitating nature of the covered condition;

(J) Transportation beyond the local area for medically necessary treatment;

(K) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical services rendered by a physician other than the physician (or his assistant) performing the surgical service, in an amount not less than (i) eighty per cent (80%) of the reasonable charges, or (ii) fifteen percent (15%) of the surgical service benefit;

(L) Home health care as described in Section 38a-493(d) of the Connecticut General Statutes;

(M) Physical, speech, hearing and occupational therapy for symptoms related to the covered condition;

(N) Special equipment and supplies, including, but not limited to hospital bed, bedpans, pulleys, wheelchairs, aspirator, disposable diapers, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;

(O) Reconstructive surgery when medically necessary;

(P) Prosthetic devices including wigs and artificial breasts;

(Q) Nursing home care;

(R) Hospice care; and

(S) any other expenses necessarily incurred in the care and treatment of the covered condition.

(2) Per diem indemnification for each person insured under the policy for a specifically named condition with no deductible amount, and an overall aggregate benefit limit of not less than two hundred and fifty thousand dollars (\$250,000) while medically confined, subject to the following minimum benefit standards:

(A) A fixed-sum payment of at least one hundred and fifty dollars (\$150.00) for each day of hospital confinement;

(B) A fixed-sum payment equal to at least one hundred dollars (\$100.00) for each day of hospital or non-hospital out-patient surgery, chemotherapy and radiation therapy; and

(C) A fixed-sum payment equal to one-half of the hospital in-patient benefit for each day of nursing home care, hospice care, and home health care for at least one hundred (100) days.

(3) A fixed-sum one-time payment made not more than thirty (30) days after submission to the insurer of proof of diagnosis of the specified condition, of not less than one thousand dollars (\$1,000). In addition, payment amounts may be limited to not less than two hundred fifty dollars (\$250) for one or more specified conditions where coverage is provided under such policy for two or more specified conditions, provided that the aggregate amount payable under the policy for all specified conditions is at least one thousand dollars (\$1,000). Also, coverage for a fixed-sum payment for a spouse or dependent may be offered to the insured, provided the benefit amount offered is at least twenty-five per cent (25%) of the benefit amount for the insured. Where coverage is advertised or otherwise represented to offer generic coverage of a specified condition, the same dollar amounts shall be payable, regardless of the particular subtype of the condition, unless such subtype is clearly identifiable and the policy clearly differentiates that subtype and its benefits.

(d) No specified disease policy shall be delivered or issued for delivery in this State unless an outline of coverage in the form prescribed below is completed and

is delivered with the policy or at the time of application for the policy. The items included in the outline of coverage shall appear in the sequence prescribed below:

CAUTION!
(COMPANY NAME)
(SPECIFIED CONDITION) COVERAGE
OUTLINE OF COVERAGE

(1) **Read Your Policy Carefully** — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions shall control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **(Specified condition) Coverage** — This policy is designed to provide, to persons insured, restricted coverage paying benefits **ONLY** when certain losses occur as a result of (specified condition) treatment (or diagnosis). This policy does **NOT** provide general health insurance.

(3) This policy is **NOT A MEDICARE SUPPLEMENT** policy. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from (the company).

(4) (A brief specific description of the benefits, including dollar amounts, contained in this policy.)

(5) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (4) above.)

(6) (A description of policy provisions respecting renewability, including age restrictions and any reservation of right to change premiums.)

(Adopted effective May 31, 1997; amended June 7, 2010)

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Group Specified Disease Health Insurance Minimum Standards

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Group Specified Disease Health Insurance Minimum Standards

Sec. 38a-513-1. Group specified disease policies

(a) A “group specified disease policy” means a group health insurance policy or certificate delivered or issued for delivery in this state which pays benefits for the diagnosis or treatment of one or more specifically named diseases, conditions or syndromes in accordance with section 38-513-1(c) of the Regulations of Connecticut State Agencies. As used in this section, “condition” includes specifically named diseases, conditions or syndromes unless the context otherwise requires. Any group specified disease policy shall meet the general requirements in subsection (b) of this section and the minimum benefit standards pursuant to subsection (c) of this section.

(b) General Requirements:

The following requirements shall apply to group specified disease policies in addition to all other requirements applicable to group accident and sickness policies.

(1) Group policies covering a single specified disease, condition, or syndrome or combination of specified diseases, conditions, or syndromes may not be sold or offered for sale other than as group specified disease policies.

(2) Any group specified disease policy issued pursuant to this section which conditions payment upon pathological diagnosis of a covered disease, condition or syndrome, shall also provide that if such a pathological diagnosis is medically inappropriate, a clinical diagnosis shall be accepted in lieu thereof.

(3) Notwithstanding any other provision of this section, group specified disease policies described in section 38a-513-1(c) (1) and section 38a-513-1(c) (2) of the Regulations of Connecticut State Agencies shall provide benefits to any covered certificate holder not only for a specified disease, condition or syndrome but also for any other disease, condition or syndrome, directly caused or aggravated by the specified disease, condition or syndrome or its treatment.

(4) All group specified disease policies shall include a provision which allows the certificate holder to continue coverage or convert to an individual specified disease policy in the event of termination of the eligibility of the certificate holder or in the event of the cancellation, nonrenewal or termination of the group specified disease policy. Conversion is to be made without evidence of insurability and without pre-existing conditions limitations or waiting periods, with an effective date that coincides with the date coverage ceased under the group plan.

(5) No group specified disease policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. Premiums paid for a certificate holder shall be refunded if the certificate holder is diagnosed with a covered disease, condition or syndrome during the waiting or probationary period. Alternatively, the certificate may provide for an additional option for the certificate holder to continue the certificate in force, but in no event shall benefits for that disease, condition or syndrome be withheld beyond the time period specified in the pre-existing condition provision.

(6) Payment of benefits may be conditioned upon a covered certificate holder receiving medically necessary care or treatment.

(7) Any application for a group specified disease policy shall contain a prominent statement above the signature of the applicant that a person who is already covered by Medicaid is not eligible for this coverage and cannot be included in the group. Such statement shall be in bold face type or contrasting color.

(8) The benefits of a group specified disease policy shall be paid regardless of other coverage.

(9) Benefit payments under group specified disease policies described in section 38a-513-1(c) (1) and section 38a-513-1(c) (2) of the Regulations of Connecticut State Agencies shall begin with the first day of care or confinement after the effective date of the policy if such care or confinement is for a covered disease, condition or syndrome even though the diagnosis of a covered disease, condition or syndrome is made at some later date (but not retroactive more than ninety (90) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of such covered disease, condition or syndrome.

(10) Group specified disease policies shall provide a thirty (30) day free look. Notice of the thirty (30) day free look shall appear on the face page of the policy and certificate in bold face equal to at least fourteen (14) point type.

(11) Group specified disease policies and certificates shall contain a prominent statement on the first page of the policy and certificate in bold face type at least equal to fourteen (14) point type as follows: “CAUTION! This policy (or certificate) PROVIDES LIMITED COVERAGE. IT IS NOT A MAJOR MEDICAL POLICY (OR CERTIFICATE). Read it carefully. It only pays benefits for treatment (or diagnosis) of (specified disease, condition or syndrome).”

(12) The premiums for a group specified disease policy shall be reasonable in relation to benefits and shall not be excessive or inadequate. The insurer shall establish premiums for group specified disease policies in accordance with generally accepted actuarial principles and practices so as to return to certificate holders in the form of aggregate benefits provided under the policy during the period for which rates are computed at least sixty five percent (65%) of the aggregate premiums earned. Each insurer shall annually report by June 30 earned premiums and incurred claims for the prior calendar year for each approved group specified disease policy form in a format acceptable to the insurance commissioner.

(13) “Preexisting condition” shall not be defined to be more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by a physician or received from a physician within a twelve (12) month period preceding the effective date of the coverage of the certificate holder. No policy shall exclude for a loss due to a preexisting condition for a period greater than twelve (12) months following the certificate holder’s effective date of coverage.

(c) Each group specified disease policy shall meet the minimum benefit standards provided in subdivision (1), (2) or (3) of this subsection. In addition, a group specified disease policy may combine coverages of the types described in subdivisions (1), (2), and (3) of this subsection. A policy that combines coverages and meets the minimum benefit standard requirements set forth in subdivision (1), (2), or (3) of this subsection may be approved for sale in the state if it includes some, but not all, of the benefits otherwise permitted by another type of group specified disease policy, except that group specified disease policies combining coverage of the types described in subdivisions (1) and (2) of this subsection shall meet the minimum requirements for each type of coverage.

(1) Coverage for medical expenses incurred by each certificate holder insured under the policy for one or more specifically named diseases, conditions or syndromes, with a deductible amount not in excess of one thousand dollars (\$1,000), co-insurance by the insured not to exceed twenty five per cent (25%), and an overall aggregate lifetime benefit limit, per certificate holder, of not less than two hundred and fifty thousand dollars (\$250,000). Any inside limits shall be reasonable. Policy benefits shall include:

- (A) Hospital room and board and hospital furnished medical services or supplies;
- (B) Treatment by, or under the direction of, a physician or surgeon;
- (C) Private duty services of a registered nurse (R.N.) or a Licensed Practical Nurse (L.P.N.);
- (D) X-ray, radium, cobalt, nuclear medicine, chemotherapy, and other therapeutic procedures used in diagnosis and treatment;
- (E) Licensed ambulance for local service to or from a local hospital;
- (F) Blood transfusions, and plasma, and the administration thereof;
- (G) Drugs and medicines prescribed by a physician;
- (H) The rental of any respirator or other mechanical apparatus;
- (I) Braces, crutches, wheelchairs and other adaptive devices deemed necessary by the attending physician because of the incapacitating nature of the covered condition;
- (J) Transportation beyond the local area for medically necessary treatment;
- (K) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical services rendered by a physician other than the physician (or his assistant) performing the surgical service, in an amount not less than (i) eighty per cent (80%) of the reasonable charges, or (ii) fifteen percent (15%) of the surgical service benefit;
- (L) Home health care as described in section 38a-520(d) of the general statutes;
- (M) Physical, speech, hearing and occupational therapy for symptoms related to the covered condition;
- (N) Special equipment and supplies, including, but not limited to, hospital bed, bedpans, pulleys, wheelchairs, aspirator, disposable diapers, oxygen, surgical dressings, rubber shields, colostomy and eleostomy appliances;
- (O) Reconstructive surgery when medically necessary;
- (P) Prosthetic devices including wigs and artificial breasts;
- (Q) Nursing home care;
- (R) Hospice care; and
- (S) Any other expenses necessarily incurred in the care and treatment of the covered condition.

(2) Per diem indemnification for each certificate holder insured under the policy for a specifically named disease, condition or syndrome with no deductible amount, and an overall aggregate benefit limit of not less than two hundred and fifty thousand dollars (\$250,000) while medically confined, subject to the following minimum benefit standards:

(A) A fixed-sum payment of at least one hundred and fifty dollars (\$150) for each day of hospital confinement;

(B) A fixed-sum payment equal to at least one hundred dollars (\$100) for each day of hospital or non-hospital out-patient surgery, chemotherapy and radiation therapy; and

(C) A fixed-sum payment equal to one-half of the hospital in-patient benefit for each day of nursing home care, hospice care, and home health care for at least one hundred (100) days.

(3) A fixed-sum one-time payment made not more than thirty (30) days after submission to the insurer of proof of diagnosis of the specified disease, condition, or syndrome of not less than one thousand dollars (\$1,000). In addition, payment amounts may be limited to not less than two hundred and fifty dollars (\$250) for one or more specified diseases, conditions, or syndromes where coverage is provided under such policy for two or more specified diseases, conditions, or syndromes, provided that the aggregate amount payable under the policy for all specified dis-

eases, conditions, or syndromes is at least one thousand dollars (\$1,000). Also, coverage for a fixed-sum payment for a spouse or dependent may be included under the policy, provided the benefit amount included is at least twenty-five per cent (25%) of the benefit amount for the certificate holder. Where coverage is advertised or otherwise represented to offer generic coverage of a specified disease, condition, or syndrome, the same dollar amounts shall be payable, regardless of the particular subtype of the disease, condition, or syndrome unless such subtype is clearly identifiable and the policy clearly differentiates that subtype and its benefits.

(d) No group specified disease policy shall be delivered or issued for delivery in this state unless an outline of coverage in the form prescribed below is completed and is delivered with the certificate. The items included in the outline of coverage shall appear in the sequence prescribed below:

CAUTION!

(COMPANY NAME)

(SPECIFIED DISEASE, CONDITION OR SYNDROME) COVERAGE

OUTLINE OF COVERAGE

(1) Read Your Certificate Carefully — This outline of coverage provides a very brief description of the important features of your certificate. This is not the insurance contract and only the actual certificate provisions shall control. The certificate sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR CERTIFICATE CAREFULLY!**

(2) (Specified disease, condition or syndrome) Coverage — This certificate is designed to provide, to certificate holders, restricted coverage paying benefits **ONLY** when certain losses occur as a result of treatment (or diagnosis) of the specified disease, condition, or syndrome. This certificate does **NOT** provide general health insurance.

(3) This certificate is **NOT A MEDICARE SUPPLEMENT** certificate. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from (the company).

(4) (A brief specific description of the benefits, including dollar amounts, contained in this certificate.)

(5) (A description of any certificate provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (4) above.)

(6) (A description of certificate provisions respecting continuation or conversion of coverage in the event of group policy termination.)

(Adopted effective November 30, 2009)

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Group Long-Term Care Insurance

Sec. 38a-528-1. Applicability and scope

Except as otherwise specifically provided, Sections 38a-528-1 to 38a-528-17, inclusive, apply to all group long-term care insurance policies, subscriber contracts or certificates delivered or issued for delivery in this state on or after the effective date of this regulation by any insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center.

(Effective September 30, 1994)

Sec. 38a-528-2. Definitions

As used in Sections 38a-528-1 to 38a-528-17, inclusive:

(a) “Long-term care policy” means any group health insurance policy or subscriber contract or certificate, or any amendment, endorsement or rider to any such policy or subscriber contract or certificate delivered or issued for delivery to any resident of this state which is designed to provide benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for at least one year after a reasonable elimination period. A long-term care policy or certificate shall provide benefits for confinement in a nursing home or confinement in the insured’s own home or both. Any additional benefits provided shall be related to long-term treatment of an injury, illness or loss of functional capacity. “Long-term care policy” shall not include any such policy, contract or certificate which is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(b) “Applicant” in the case of a group long-term care policy or subscriber contract means the proposed certificateholder.

(Effective September 30, 1994)

Sec. 38a-528-3. Policy definitions and terms

No insurance policy or subscriber contract or certificate may be advertised, solicited or issued for delivery to any resident of this state as a long-term care policy or certificate unless the terms used in such policy, subscriber contract or certificate conform to the meanings given in this section.

(a) “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.

(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) Such definition may be further modified to exclude injuries for which benefits are provided under any workers’ compensation, employers’ liability or similar law, or the basic reparations benefits of a no-fault motor vehicle insurance plan.

(b) “Activities of daily living” means activities such as, for example, bathing, dressing, eating, toileting, and transferring from bed to chair.

(c) "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.

(d) "Adult day care" shall not be defined more restrictively than a program of services prescribed by a physician and provided by an organization that provides a program of adult day care outside the home which: is licensed in accordance with applicable state laws; has a full-time director; has one or more registered nurse (R.N.s) or licensed practical nurses (L.P.N.s) in attendance during operating hours for at least 4 hours a day; operates at least 5 days a week for a minimum of 6 hours a day; maintains a written record of medical services given to each client; and has established procedures for obtaining appropriate aid in the event of a medical emergency.

(e) "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall be defined in relation to its status, facilities and available services. A definition of such home or facility shall not be more restrictive than one requiring that it: (1) be operated pursuant to law; (2) be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested; (3) be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under supervision of a duly licensed physician; (4) provide continuous twenty-four hours a day nursing service by or under the supervision of a registered nurse (R.N.); and (5) maintains a daily medical record of each patient. The definition of such home or facility may provide that such term shall not be inclusive of: (1) any home, facility or part thereof used primarily for rest; (2) a home or facility for the aged or for the care of drug addicts or alcoholics; or (3) a home or facility primarily used for the care and treatment of mental disease or disorders, or custodial or educational care.

(f) "Custodial care" shall not be defined more restrictively than care which is (1) provided primarily to assist the insured in the activities of daily living; (2) can be provided without professional skills or training; and (3) could not be omitted without adversely affecting the insured's physical or mental condition.

(g) A "custodial or intermediate nursing home" is an institution which: (1) is licensed as a nursing home or operated under the law as a nursing home or a hospice; (2) operates primarily to provide nursing care for which a charge is made for three or more persons; (3) provides continuous nursing care under the supervision of a licensed registered nurse (R.N.), a licensed practical nurse (L.P.N.) or a licensed physician; (4) is not a hospital or clinic; (5) is not a home for the aged or mentally ill, a rest home, a community living center, or a place that provides domiciliary, residency, or retirement care; and (6) is not a facility which operates primarily for the treatment of alcoholics or drug addicts, even if it is a section of a nursing home.

(h) "Home health care services" shall not be defined more restrictively than medical and non-medical services, provided to ill, disabled or infirm persons who reside at home. Such services may include, for example, homemaker/home health aide services, personal care services, adult day care, respite care services and hospice care services.

(i) "Hospice Care" shall not be defined more restrictively than a program that: (1) provides support and care to an insured who is terminally ill, with no reasonable prospect of cure, and who has a life expectancy of 6 months or less as estimated by a physician; (2) is prescribed by and under the direction of a physician; (3) is provided by an organization that meets applicable federal or state requirements for certification or licensing as a hospice care organization. Hospice Care may be defined to exclude services provided to someone other than the insured.

(j) "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. (1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital: (A) be an institution operated pursuant to law; and (B) be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and (C) provide twenty-four hour nursing service by or under the supervision of registered nurses (R.N.s). (2) The definition of the term "hospital" may state that such term shall not be inclusive of: (A) convalescent homes, convalescent, rest, or nursing facilities; (B) facilities primarily affording custodial, educational or rehabilitative care; (C) facilities for the aged, drug addicts or alcoholics; or (D) any military or veterans' or soldiers' home or any hospital contracted or operated by any national government or agency thereof for the treatment of members or former members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(k) "Loss of Functional Capacity" shall mean that the insured requires care to assist in meeting day-to-day living requirements such as, but not limited to, eating, bathing and dressing.

(l) "Medicare" shall be 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.

(m) "Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neuroses, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, except that Alzheimer's disease shall not be considered a mental or nervous disorder.

(n) "Necessary Care for Confinement in the Insured's Own Home" shall not be defined more restrictively than home health care services provided to an insured who has suffered a loss of functional capacity.

(o) "Necessary Care for Confinement in a Nursing Home" shall not be defined more restrictively than admitted upon recommendation of a physician, other than the proprietor or employee of the skilled nursing care facility, for care which is medically necessary and which is not at first custodial or intermediate in nature but may, after admission, be reduced to a level that is primarily custodial or intermediate.

(p) "One Period of Confinement" means consecutive days of confinement; it shall be deemed to include successive periods of confinement which are due to the same or related cause and are not separated by at least ninety (90) days during which the covered person is not confined whether at home or in an institution for either skilled nursing care, intermediate or custodial care.

(q) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

(r) "Physician" shall be defined as a person who is licensed by the state in which he or she practices to give treatment for which benefits are provided under the policy and who is acting within the scope of his or her license.

(s) "Sickness or Illness" shall not be defined more restrictively than the following: Sickness or illness means disease of an insured person which first manifests itself

after the effective date of insurance and while the insurance is in force. The definition may be further modified to exclude diseases for which benefits are provided under any workers' compensation, employers' liability or similar law.

(Effective September 30, 1994)

Sec. 38a-528-4. Minimum standards

No group insurance policy or subscriber contract or certificate shall be advertised, solicited or issued for delivery in this state as a long-term care policy or certificate which does not meet the following minimum standards. These are minimum standards and 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 regulation.

(a) Continuation.

(1) All group long-term care policies or subscriber contracts and certificates shall include a provision which allows the certificateholder to continue coverage or convert to an individual long-term care policy or subscriber contract in the event of the cancellation, nonrenewal or termination of the group policy or contract. Conversion is to be made without evidence of insurability and without pre-existing conditions limitations or waiting periods, with an effective date that coincides with the date coverage ceased under the group plan.

(2) 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 continue coverage under the group policy or convert to an individual long-term care policy or subscriber contract upon termination of the qualifying relationship by death or dissolution of marriage. Conversion is to be made without evidence of insurability and without pre-existing conditions limitations or waiting periods, with an effective date that coincides with the date coverage ceased under the group plan.

(3) If a group long-term care policy or subscriber contract is replaced by another policy or contract issued to the same policyholder, the succeeding carrier shall offer coverage to all persons covered under the previous policy or contract on the date of its termination. Coverage shall be made available without evidence of insurability or pre-existing conditions limitations or waiting periods and with an effective date that coincides with the termination of coverage under the preceding policy.

(b) A long-term care policy shall not deny a claim for loss which occurs or confinement which begins more than six (6) months from the effective date of coverage for a pre-existing condition. The policy or subscriber contract shall not define a pre-existing 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.

(c) A long-term care policy shall not indemnify against losses resulting from sickness on a different basis from losses resulting from accidents.

(d) **Limitations and Exclusions.** A long-term care policy or certificate shall not include limitations or exclusions which are more restrictive than the following:

(1) **PRE-EXISTING CONDITIONS LIMITATION** - This policy (or certificate) does not pay benefits for loss which occurs or confinement which begins within six months after the effective date of coverage as a result of a pre-existing condition.

(2) **OTHER EXCLUSIONS** - This policy (or certificate) does not cover: (i) loss which is caused by declared or undeclared war or any act thereof; (ii) loss which is caused by mental disease or disorder without demonstrable organic disease; (iii) loss which is caused by suicide or any attempt thereof (while sane or insane), or intentionally self-inflicted injury; (iv) confinement in a government institution unless

a charge is made which the covered person is obligated to pay; (v) confinement due to alcoholism or drug addiction; (vi) confinement in a hospital; or (vii) confinement or care received outside of the United States.

(3) A policy (or certificate) may provide that its benefits shall not duplicate benefits payable by Medicare.

(e) No long-term care policy shall use waivers to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions.

(f) Long-term care policies shall make reasonable provision for waiver of premium. As to benefits for institutional confinement, this requirement is met if the policy provides for a waiver of premium after benefits have been paid for ninety (90) consecutive days and thereafter during the continuance of the consecutive days for which benefits are paid.

(g) Long-term care certificates, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the first page of the certificate or attached thereto stating in substance that the insured person shall have the right to return the certificate to the insurer or its agent within thirty (30) days of its delivery and to have the premium refunded if, after examination of the certificate, the insured person is not satisfied for any reason. Long-term care certificates issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured person shall have the right to return the certificate to the insurer within thirty (30) days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

(h) Long-term care policies shall not condition benefits upon prior hospitalization or institutionalization.

(i) Long-term care policies must include a provision which states that upon notification to the company of a person's death, the company will refund on a pro-rata basis any part of a periodic premium paid by that person which applies to the period after death.

(j) Long-term care policies shall not have an elimination period greater than one hundred (100) days of confinement.

(k) Long-term care certificates shall include a provision that coverage thereunder shall be incontestable, except for nonpayment of premium, after it has been in force for two years from its date of issue.

(l) **Extension of Benefits.** Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

(m) The premiums charged to an insured for long-term care insurance shall not increase due solely to either the increasing age of the insured at ages beyond sixty-five (65) or the duration the insured has been covered under the policy.

(n) The requirement that a long-term care insurance policy provide benefits for at least one year of confinement after a reasonable elimination period shall be met by providing benefits solely for confinement in a nursing home, solely for confinement at home, or for confinement either in a nursing home or at home.

(o) **Payment of Benefits.** A long-term care policy 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.

(p) Long-term care certificates which only provide benefits for confinement in the insured’s own home shall include a statement to that effect on the first page of the certificate in bold print.

(q) A long-term care insurance policy that provides benefits for home health care, shall not limit or exclude such benefits (1) by requiring that the insured would need skilled care in a skilled nursing facility if home care services were not provided; (2) by requiring that the insured 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 home care worker acting within the scope of his or her licensure or certification; (5) by excluding coverage for personal care services provided by a home health aide; (6) 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; (7) by requiring that the insured have an acute condition before home health care services are covered; (8) by limiting benefits to services provided by Medicare-certified agencies or providers; (9) by excluding coverage for adult day care, hospice care, skilled nursing care, or physical, occupational, respiratory or speech therapy.

(r) The application for every long-term care certificate shall include a section inviting the applicant to give the name of an individual who is to receive notice of lapse concurrently with any such notice sent to the certificateholder. Along with space for the name and address of such individual, this section shall include a notice to the applicant as follows (or in substantially similar language): YOU WILL RECEIVE NOTICE IF YOUR COVERAGE IS ABOUT TO LAPSE (TERMINATE) BECAUSE YOU HAVE NOT PAID PREMIUMS. WE WILL BE GLAD TO SEND A COPY OF THIS NOTICE TO ANOTHER PERSON, IF YOU WOULD LIKE. THAT PERSON WILL NOT BE RESPONSIBLE FOR PAYMENT OF THE PREMIUM, AND YOU WILL ALWAYS RECEIVE YOUR OWN COPY OF THE NOTICE. IF YOU WANT AN EXTRA COPY SENT TO ANOTHER PERSON, PLEASE GIVE US THAT PERSON’S NAME AND ADDRESS.

(Effective September 30, 1994)

Sec. 38a-528-5. Prohibition against pre-existing conditions and probationary periods in replacement coverage

If a long-term care certificate replaces another long-term care certificate or individual policy, the replacing insurer shall waive any time periods applicable to pre-existing conditions and probationary periods in the new long-term care certificate for similar benefits to the extent that similar exclusions have been satisfied under the original certificate or policy.

(Effective September 30, 1994)

Sec. 38a-528-6. Required disclosure provisions

(a) **Continuation.** Group long-term care certificates shall contain a provision, appropriately captioned, which describes how the coverage may be continued or converted.

(b) **Riders and Endorsements.** Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured or exercises a specifically reserved right under a long-term care certificate, all riders or endorsements added to a long-term care certificate after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage shall require a signed acceptance by the insured. Any rider or endorsement added to a long-term care certificate after date of issue which increases benefits or coverage with a concomitant increase in premium shall be agreed to in writing signed by the insured, except 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 certificate, rider or endorsement.

(c) **Limitations.** If a long-term care insurance policy contains any limitation with respect to pre-existing conditions, such limitations shall appear as a separate paragraph of the certificate and shall be labeled “PRE-EXISTING CONDITIONS LIMITATION.”

(d) **Other Limitations or Conditions on Eligibility for Benefits.** A long-term care insurance certificate shall set forth a description of any limitations or conditions for eligibility, including any required number of days of confinement, in a separate paragraph labeled “Limitations or Conditions on Eligibility for Benefits.”

(Effective September 30, 1994)

Sec. 38a-528-7. Prohibition against post claims underwriting

(a) All applications for long-term care insurance certificates 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. 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 shall not be rescinded for that condition.

(c) Except for certificates which are guaranteed issue:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant’s signature block on an application for long-term care insurance:

Caution: If your answers on this application are incorrect or untrue, (company) has the right to deny benefits or rescind your coverage.

(2) The following language or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance certificate at the time of delivery:

Caution: The issuance of this long-term care insurance is based upon your responses to the questions on your application. A copy of your application (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 coverage. 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)

(d) A copy of the completed application shall be delivered to the insured no later than at the time of delivery of the certificate unless it was retained by the applicant at the time of application.

(e) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all coverage rescissions, both state and countrywide, except those which the insured voluntarily effectuated.

(Effective September 30, 1994)

Sec. 38a-528-8. Filing requirements

(a) All filings of rates and rating schedules shall be accompanied by an actuarial certification demonstrating that expected claims in relation to premiums comply with the loss ratio required by subsection (b) of Section 38a-528 of the General Statutes 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 required loss ratio standard.

(b) Insurers shall submit a description of the method used to determine the standard for the payment of policy benefits with each policy form subject to subsection (o) of Section 38a-528-4 which they file for approval.

(c) Every insurer, fraternal benefit society, hospital service corporation, medical service corporation or health care center providing group long-term care insurance in this State shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance for review or approval to the extent this may be required in accordance with regulations adopted pursuant to Section 38a-819 of the General Statutes. All such advertisements shall be retained as provided in Section 38a-819-18 of these regulations.

(Effective September 30, 1994)

Sec. 38a-528-9. Standards for marketing

(a) Every insurer, fraternal benefit society, hospital service corporation, medical service corporation or health care center marketing long-term care insurance coverage in this state, directly or through its producers shall:

(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 certificate the following:

“Notice to buyer: This policy 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 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 other entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subsection.

(6) Provide, at solicitation, written notice to the prospective certificateholder of the availability of any insurance counselling program that may be provided or

approved by any state agency for this purpose, together with the name, address and telephone number of such program.

(b) In addition to the practices prohibited in Sections 38a-815 to 38a-831, inclusive, of the General Statutes 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.

(Effective September 30, 1994)

Sec. 38a-528-10. Suitability of recommended purchase

(a) An agent who recommends the purchase or replacement of a long-term care policy or certificate shall have reasonable grounds for believing that the recommendation is suitable for the applicant upon the basis of the facts, if any, disclosed by the applicant concerning his or her health and financial circumstances.

(b) Before selling any group long-term care certificate, an agent shall make reasonable efforts to obtain information concerning the applicant's health and financial circumstances.

(c) Before issuing any group long-term care certificate, a direct response insurer shall have reasonable grounds for believing that the purchase of such certificate, whether or not it involves the replacement of existing coverage, is suitable for the applicant upon the basis of the facts, if any, disclosed by the applicant concerning his or her health and financial circumstances.

(d) Every direct response insurer shall include questions on its applications for long-term care insurance that are reasonably designed to obtain information concerning the applicant's health and financial circumstances.

(Effective September 30, 1994)

Sec. 38a-528-11. Requirement to deliver shopper's guide

A long-term care insurance shopper's guide approved by the Commissioner shall be provided to all prospective applicants for a long-term care insurance certificate.

(a) In the case of agent solicitations, an agent shall deliver the shopper's guide prior to the presentation of an application.

(b) In the case of direct response solicitations, the shopper's guide shall be presented in conjunction with any application.

(Effective September 30, 1994)

Sec. 38a-528-12. Requirement to offer a non-forfeiture benefit

No insurer shall offer for sale a long-term care insurance certificate unless the insurer also offers the applicant the option to purchase a certificate that provides a non-forfeiture benefit. An insurer shall meet this requirement by providing return of premium, full benefits for a reduced benefit period, reduced benefits for the full

benefit period, or another benefit that is acceptable to the Commissioner. A certificate that provides a non-forfeiture benefit shall include a schedule of this benefit.

(Effective September 30, 1994)

Sec. 38a-528-13. Requirement to offer inflation protection

(a) No insurer shall offer for sale a long-term care insurance certificate unless the insurer also offers the applicant the option to purchase a certificate that provides for meaningful periodic benefit level increases to account for reasonably anticipated increases in the costs of long-term care services. Insurers shall offer each applicant, at the time of purchase, the option to purchase a certificate with an inflation protection feature no less favorable than one of the following:

(1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);

(2) Guarantees 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 no less 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; or

(3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(b) Insurers shall include the following information in or with the outline of coverage:

(1) A graphic comparison of the benefit levels of coverage where benefits increase over a period of time with coverage where benefits do not increase. 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.

An insurer may use a reasonable graphic demonstration for the purposes of this disclosure.

(c) Inflation protection benefit increases under a certificate 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.

(d) 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 the fact that the premium may change in the future unless the premium is guaranteed to remain constant.

(e) Inflation protection as provided in subsection (a) of this section shall be included in a long-term care insurance certificate unless the insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection shall be considered 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 insurance with and without inflation protection. Specifically, I have reviewed Plans ___, and I reject inflation protection.

(Effective September 30, 1994)

Sec. 38a-528-14. Standard format outline of coverage

(a) No long-term care certificate shall be delivered or issued for delivery to any resident of this state unless an appropriate outline of coverage in the format prescribed herein is completed as to such certificate, and is delivered to the applicant at the time

application or solicitation is made and acknowledgement of receipt or certification of delivery of such outline of coverage is provided to the insurer. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of such request, shall make such delivery no later than the time when the certificate is delivered.

(b) The outline of coverage shall be a free standing document, using no smaller than twelve point type.

(c) The outline of coverage shall contain no material of an advertising nature.

(d) 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.

(e) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(f) Format for outline of coverage:

(COMPANY NAME)
(ADDRESS - CITY & STATE)
(TELEPHONE NUMBER)
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE
(Policy Number)

(Except for certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.)

Caution: The issuance of this long-term care insurance certificate is based upon your responses to the questions on your application. A copy of your application (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 coverage. 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 certificate, which was delivered in Connecticut, evidences coverage under a group policy of insurance.

2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of your coverage. You should compare this outline of coverage to outlines of coverage for other insurance available to you. This is not an insurance contract, but only a summary of coverage. Only the group policy and your certificate contain the governing contractual provisions of your insurance. This means that the certificate and the group policy set 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 CERTIFICATE CAREFULLY!**

3. **TERMS UNDER WHICH THE 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 contains provisions providing for a refund or partial refund of premium upon the death of an insured and does or does not contain provisions providing for such a refund upon surrender of the policy. Include a description of all such refund provisions.)

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 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 level of care provided.)

(c) (Non-institutional benefits, by level of care provided.)

(An explanation of any qualifying criteria used to determine an insured's eligibility for benefits shall accompany each benefit description. If an attending physician or other specified person must certify to a loss of functional capacity in order for the insured to be eligible for benefits, this shall be specified. If activities of daily living (ADLs) are used to determine an insured's eligibility for benefits then these shall be explained.)

7. **LIMITATIONS AND EXCLUSIONS**

(Describe:

(a) Any pre-existing conditions provision;

(b) Non-eligible facilities/providers (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(c) Non-eligible levels of care;

(d) Exclusions/exceptions;

(e) Other 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 provision;

(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, indicate 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, indicate whether there will be any additional premium charge imposed, and describe how that is to be calculated.)

9. TERMS UNDER WHICH INSURANCE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) (Describe policy provisions for continuation or conversion);

(b) (Describe waiver of premium provisions, including whether the insured is entitled to a refund of unearned premium in the event of a waiver);

(c) (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 any qualifying criteria that determines such an insured's eligibility for policy benefits.)

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 whether medical underwriting is used;

(b) Describe other important features.)

(Effective September 30, 1994)

Sec. 38a-528-15. Replacement

(a) 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 or certificate in force or whether a long-term care certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. 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.

(1) Do you have another long-term care insurance policy or certificate in force (including a 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, with which company? 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 insurance?

(b) Agents shall list any other health insurance they have sold to the applicant.

(1) List coverage sold which is still in force.

(2) List coverage sold in the past five (5) years which is no longer in force.

(c) Solicitations Other than Direct Response. 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 group long term care insurance certificate, a notice regarding replacement of

accident and sickness or long-term care coverage. One 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 group long-term care insurance to be issued by (company name) Insurance Company. Your new certificate provides thirty (30) days within which you may decide, without cost, whether you desire to keep the insurance. 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 certificate.

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 coverage 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 (pre-existing conditions) may not be immediately or fully covered under the new insurance. This could result in denial or delay in payment of benefits under the new coverage, whereas a similar claim might have been payable under your present insurance.

2. State law provides that your replacement coverage may not contain new pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new coverage for similar benefits to the extent such time was spent (depleted) under the original coverage.

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 insurance. 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 insurance 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 insurance 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)

(d) Direct Response Solicitations. 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 certificate. 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 group long-term care insurance evidenced by a certificate delivered herewith issued by (company name) Insurance Company. Your new certificate provides thirty (30) days within which you may decide, without cost, whether you desire to keep the insurance. 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 certificate.

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 insurance 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 (pre-existing conditions), may not be immediately or fully covered under the new insurance. This could result in denial or delay in payment of benefits under the new insurance, whereas a similar claim might have been payable under your present insurance.

2. State law provides that your replacement coverage may not contain new pre-existing conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new or coverage for similar benefits to the extent such time was spent (depleted) under the original coverage.

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 insurance. 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 certificate) If, after due consideration you still wish to terminate your present insurance and replace it with new coverage read the copy of the application attached to your new certificate 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)

(e) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing coverage 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 coverage is issued, whichever is sooner.

(Effective September 30, 1994)

Sec. 38a-528-16. Reporting requirements

(a) Every insurer shall report annually by June 30 the number of certificates lapsed in the previous calendar year, the average total number of certificates in force during the preceding calendar year, and the resulting ratio.

(b) Every insurer shall report annually by June 30 the number of replacement certificates sold in the previous calendar year, the total number of certificates sold during the preceding calendar year, and the resulting ratio.

(c) Every insurer shall report annually by June 30 the number of replacement certificates sold in the previous calendar year, the average total number of certificates in force during the preceding calendar year, and the resulting ratio.

(d) Every insurer shall report annually by June 30 the number of rescissions of certificates, except those voluntarily effectuated by an insured, in the previous calendar year.

(e) For purposes of this section, “certificates” shall mean certificates evidencing coverage under group long-term care insurance policies or subscriber contracts and “report” shall mean on a statewide and national basis.

(Effective September 30, 1994)

Sec. 38a-528-17. Effective date; separability

(a) The effective date of Sections 38a-528-1 to 38a-528-17, inclusive, shall be September 30, 1994.

(b) If any provision of Sections 38a-528-1 to 38a-528-17, inclusive, or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of these regulations and the application of such provision to other persons or circumstances shall not be affected thereby.

(Effective September 30, 1994)

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Group Coverage Discontinuance and Replacement

Sec. 38a-546-1. Applicability and scope

Section 38a-546-1 to 38a-546-5, inclusive, of the Regulations of Connecticut State Agencies, shall apply to all group insurance policies in effect, delivered, or issued for delivery in this state. The provisions of section 38a-546-5(a) of the Regulations of Connecticut State Agencies shall be effective for all covered persons whose group health insurance plan terminates on or after the effective date of section 38a-546-1 to 38a-546-5, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective September 25, 1992; amended August 30, 2004)

Sec. 38a-546-2. Definitions

As used in section 38a-546-1 to section 38a-546-4, inclusive, of the Regulations of Connecticut State Agencies:

(1) “Carrier” means a health care center, insurer, hospital and medical service corporation or other entity responsible for the payment of benefits or provision of services under a group contract;

(2) “Commissioner” means the Insurance Commissioner;

(3) “Group disability income protection policy” means a contract for coverage of the type specified in subdivision (5) of section 38a-469 of the Connecticut General Statutes that by its terms limits eligibility to members or employees of a specified group;

(4) “Group health insurance policy” means a contract for coverage of the type specified in subdivisions (1), (2), (3), (4), (11) and (12) of section 38a-469 of the Connecticut General Statutes that by its terms limits eligibility to members or employees of a specified group;

(5) “Group hospital confinement indemnity policy” means a contract for coverage of the type specified in subdivision (3) of section 38a-469 of the Connecticut General Statutes that by its terms limits eligibility to members or employees of a specified group;

(6) “Group insurance policy” means any group health insurance policies, group life plans, group disability income protection policies, and their associated subscriber contracts, certificates, or agreements, if any; and

(7) “Group life plan” means a contract for life insurance issued to members or employees of a specified group as set forth in section 38a-431 of the Connecticut General Statutes.

(Adopted effective September 25, 1992; amended August 30, 2004)

Sec. 38a-546-3. Effective date of discontinuance for nonpayment of premium or subscription charges

(a) If a group insurance policy provides for automatic discontinuance of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for such payment, the carrier shall be liable for valid claims for covered losses incurred prior to the end of the grace period.

(b) If the actions of the carrier after the end of the grace period indicate that it considered the policy or contract as continuing in force beyond the end of the grace period (such as by not denying claims for losses beginning after the end of the grace period), the carrier shall be liable for valid claims for losses beginning prior to the effective date of written notice of discontinuance to the policyholder or other entity responsible for making payments or submitting subscription charges to the

carrier. The effective date of discontinuance shall not be prior to midnight at the end of the third scheduled work day after the date upon which the notice is delivered.

(Adopted effective September 25, 1992; amended August 30, 2004)

Sec. 38a-546-4. Requirements for notice of discontinuance

(a) Any notice of discontinuance so given by the carrier shall include a request to the group policyholder or other entity involved to notify employees or members covered under the policy or subscriber contract of the date as of which the group policy or contract will discontinue and to advise that, unless otherwise provided in the policy or contract, the carrier shall not be liable for claims for losses incurred after such date. Such notice of discontinuance shall also advise, in any instance in which the plan involves employee or member contributions, that if the policyholder or other entity continues to collect contributions for the coverage beyond the date of discontinuance, the policyholder or other entity may be held solely liable for the benefits with respect to which the contributions have been collected.

(b) The carrier will prepare and furnish to the policyholder or other entity at the same time a supply of a notice form to be distributed to the employees or members concerned indicating such discontinuance and the effective date thereof, and urging the employees or members to refer to their certificates or contracts in order to determine what rights, if any, are available to them upon such discontinuance.

Nothing in this section shall relieve the employer from the notice of cancellation, discontinuance or substitution of coverage requirements in section 38a-537 of the General Statutes.

(Effective September 25, 1992)

Sec. 38a-546-5. Group extension of benefits, continuation of benefits, conversion, and pre-existing conditions

(a) **Extension of benefits.** In accordance with section 38a-546 of the Connecticut General Statutes, every group insurance policy shall provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group insurance policy, as follows:

(1) In the case of a group life plan that contains a disability benefit extension of any type (e.g., premium waiver extension, extended death benefit in event of total disability, or payment of income for a specified period during total disability), the discontinuance of the group insurance policy shall not operate to terminate such extension.

(2) In the case of a group disability income protection policy or group hospital confinement indemnity policy, discontinuance of the policy during a disability shall have no effect on benefits payable for that disability or confinement.

(3) In the case of a group health insurance plan, the extension of benefits provision shall provide coverage set forth in subparagraphs (A), (B), and (C) of this subdivision.

(A) No succeeding carrier. When there is no succeeding group health insurance plan sponsored by the employer and insured by another carrier, for covered individuals who were confined to a health care facility or totally disabled, on the date the policy is discontinued, the group health insurance plan shall provide coverage for the confinement including professional services and supplies rendered during the confinement in the health care facility and for all services related to the disabling condition, as applicable, without premium payment, according to the terms of its plan.

(i) Length of extension. The extension will apply until the date the covered individual is not confined to a health care facility, or for those not confined to a

health care facility - not totally disabled, or the date that is twelve calendar months following the date the policy was discontinued, whichever is earlier.

(ii) Submission of claim. Extension of benefits will be available provided that evidence of the facility confinement, if any, and any disabling condition is submitted within one year of the termination of the plan and claims for coverage are submitted in accordance with the plan terms.

(B) Succeeding carrier for person confined in a health care facility. When the group health insurance plan is replaced by a succeeding group health insurance plan sponsored by the employer and insured by another carrier, for covered individuals who were confined to a health care facility on the date the policy is discontinued, the prior group health plan shall provide coverage for the confinement including professional services and supplies rendered during the confinement in the health care facility, without premium payment.

(i) Length of extension. The extension will apply until the date the covered individual is not confined to a health care facility, or the date that is twelve calendar months following the date the policy was discontinued, whichever is earlier.

(ii) Submission of claim. Extension of benefits will be available provided that evidence of facility confinement and any disabling condition is submitted within one year of the termination of the plan and claims for coverage are submitted in accordance with the plan terms.

(iii) Transition of care. The succeeding carrier shall be responsible for all other coverage for the individual, including transition of care benefits that provide the individual with a reasonable opportunity to use their current health care provider(s) for a period of time that is clinically appropriate for the treatment of the condition related to the confinement. During the transitional period, benefits under the succeeding carrier's plan for treatment of the condition related to the confinement will not be reduced because of lack of participation in the succeeding carrier's network or lack of certification by the succeeding carrier for services pre-certified by the prior carrier. Nothing herein shall be construed as authorizing or requiring medical necessity certification procedures between the managed care organization and the provider that are not set forth in the contract between the managed care organization and the provider.

(C) Succeeding carrier for a totally disabled person not confined in a health care facility. When the group health insurance plan is replaced by a succeeding group health insurance plan sponsored by the employer and insured by another carrier, for covered individuals who are totally disabled but not confined to a health care facility on the date the policy is discontinued, the succeeding group health plan shall provide coverage in accordance with the plan terms.

(i) Transition of care. The succeeding carrier shall be responsible for all coverage for the totally disabled individual, including transition of care benefits that provide the individual with a reasonable opportunity to use their current health care provider(s) for a period of time that is clinically appropriate for the treatment of the disabling condition. During the transitional period, benefits under the succeeding carrier's plan for treatment of the disabling condition will not be reduced because of lack of participation in the succeeding carrier's network or lack of certification by the succeeding carrier for services pre-certified by the prior carrier. Nothing herein shall be construed as authorizing or requiring medical necessity certification procedures between the managed care organization and the provider that are not set forth in the contract between the managed care organization and the provider.

(b) **Continuation of benefits.** Pursuant to sections 38a-546 and 38a-538 of the Connecticut General Statutes, in the case of a group health insurance plan, the

continuation of benefits provision shall contain the following provisions for continuation of benefits:

(1) Regardless of an individual's eligibility for other group insurance, during an employee's absence due to illness or injury, coverage for such employee and their covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence, whichever is sooner. Such individual may be required to contribute up to that portion of the premium the individual would have been required to contribute had the employee remained an active covered employee. This provision does not obligate the employer to pay the individual's premium if the individual does not pay the premium.

(2) In any case in which coverage has been continued pursuant to section 38a-546 of the Connecticut General Statutes, the individual may be required to pay up to the rate allowed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time (COBRA). This provision does not obligate the employer to pay the individual's premium if the individual does not pay the premium except, pursuant to section 38a-554(b) of the Connecticut General Statutes, upon termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination of the group plan shall be continued without premium payment during the continuance of such disability for a period of twelve calendar months following the calendar month in which the plan was terminated, provided claim is submitted for coverage within one year of the termination of the plan.

(3) Any individual whose coverage has been continued, as of the date the contract is replaced, shall be covered by the succeeding carrier's plan of benefits for the duration of the continuation of coverage period, provided that within 31 days after the date of the replacement the succeeding carrier is paid the premium necessary to continue coverage for the individual.

(c) **Conversion.** All group insurance policies shall include a provision explaining the conversion privileges available upon termination of coverage or at the end of an extension of benefits provision.

(d) **Pre-Existing Condition.** In the case of a pre-existing conditions limitation included in the succeeding carrier's plan, the level of benefits applicable to pre-existing conditions of persons becoming covered by the succeeding carrier's plan in accordance with this subsection during the period of time this limitation applies under the new plan shall be the lesser of:

(1) The benefits of the new plan determined without application of the pre-existing conditions limitation, or

(2) The benefits of the prior plan.

(e) In any situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier.

(f) Any applicable extension of benefits or accrued liability shall be described in every group insurance policy. The benefits payable during any period of extension or accrued liability may be subject to the group insurance policy regular benefit limitations (e.g., benefits ceasing at exhaustion of a benefit period or of maximum benefits).

(Adopted effective September 25, 1992; amended August 30, 2004)

Sec. 38a-546-6.

Repealed, August 30, 2004.

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Coordination of Benefits

Sec. 38a-554-1. Authority

The following regulations are promulgated under the authority set forth in Section 38a-554 of the Connecticut General Statutes.

(Effective September 25, 1992)

Sec. 38a-554-2. Definitions

(A) "Plan" means any group policy issued by or reinsured through the Health Reinsurance Association or any subscriber contract issued by a residual market mechanism established by hospital and medical service corporations and providing comprehensive health care coverage as provided in Chapter 700c of the Connecticut General Statutes.

The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

(B) "This Plan" means those portions of the policy which provide the benefits that are subject to this provision.

(C) "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

(D) "Claim Determination Period" means a calendar year, or that portion of a calendar year during which the person for whom claim is made has been covered under this Plan.

(Effective September 25, 1992)

Sec. 38a-554-3. Effect on benefits

(A) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such Claim Determination Period, the sum of (1) the benefits that would be payable under this Plan in the absence of this provision, and (2) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.

(B) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other plans, except as provided in item (C) of this section, shall not exceed the total of such Allowable Expenses. Benefits payable under another plan include the benefits that would have been payable had claim been duly made therefor.

(C) If (1) another plan which is involved in item (B) of this section and which contains a provision coordinating its benefits with those of this plan would, according to its rules, determine its benefits after the benefits of this plan have been determined, and (2) the rules set forth in item (D) of this section would require this plan to

determine its benefits before such other plan, then the benefits of such other plan will be ignored for the purposes of determining the benefits under this plan.

(D) For the purposes of item (C) of this section, the rules establishing the order of benefit determination are:

(1) The benefits of plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a plan which covers such person as a dependent;

(2) (i) except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either plan does not have the provisions of this paragraph (2) (i) regarding dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph (2) (i) shall not apply, and the rule set forth in the plan which does not have the provisions of this paragraph (2) (i) shall determine the order of benefits.

(ii) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody;

(iii) In the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody;

(iv) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding paragraphs (ii) and (iii) above, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

(3) When rules (1) and (2) do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time, provided that:

(i) The benefits of a plan covering the person on whose expenses claim is based as a laid-off or retired employee, or dependent of such person, shall be determined after the benefits of any other plan covering such person as an employee, or dependent of such person; and

(ii) if either plan does not have a provision regarding laid-off or retired employees, which results in each plan determining its benefits after the other, then the provisions of (i) above shall not apply.

(E) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this plan during any claim determination

period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this plan.

(Effective September 25, 1992)

Sec. 38a-554-4. Right to receive and release necessary information

For the purposes of determining the applicability of and implementing the terms of this provision of this plan or any provision of similar purpose of any other plan, the company may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the company deems to be necessary for such purposes. Any person claiming benefits under this plan shall furnish to the company such information as may be necessary to implement this provision.

(Effective September 25, 1992)

Sec. 38a-554-5. Facility of payment

Whenever payments which should have been made under this plan in accordance with this provision have been made under any other plans, the company shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this plan and, to the extent of such payments, the company shall be fully discharged from liability under this plan.

(Effective September 25, 1992)

Sec. 38a-554-6. Right of recovery

Whenever payments have been made by the company with respect to Allowable Expenses in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the company shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the company shall determine: any persons to or for or with respect to whom such payments were made, any other insurance companies, any other organizations.

(Effective September 25, 1992)

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Utilization Review, Grievances and External Review

Sec. 38a-591-1. Utilization review company licenses

(a) No utilization review company shall conduct utilization review in this state unless it has been licensed by the commissioner in accordance with section 38a-591j of the Connecticut General Statutes. All requests for licensure shall be made in a manner and on a form prescribed annually by the commissioner.

(b) Applications for licensure will not be considered complete and eligible for processing until all required information is provided.

(c) The annual license fee shall be submitted in check form made payable to the ‘‘Treasurer – State of Connecticut’’.

(d) All licenses shall be renewed no later than October 1 annually.

(e) The annual license fee will not be pro-rated if issued for a period less than a full year.

(Effective September 4, 2012)

Sec. 38a-591-2. Compensation based on certification denials – prohibited

(a) No staff member, officer or consultant of a utilization review company or a health carrier shall receive any financial incentive based on the number of denials of certifications made.

(b) No utilization review company or health carrier shall receive any financial incentive based on the number of denials of certifications made.

(Effective September 4, 2012)

Sec. 38a-591-3. Confidentiality

(a) Each utilization review company shall comply with the provisions of this section as well as all applicable federal and state laws to protect the confidentiality of patient medical records. Each utilization review company shall:

(1) Secure each case file by assigning case identification numbers to all utilization review requests, and use such numbers in lieu of personally identifiable information, whenever feasible.

(2) Ensure that all paper copies of files are reasonably secured in appropriate storage facilities.

(3) Maintain appropriate written procedures for the requesting, maintenance, and disposition of patient medical records.

(4) Develop and maintain specifications indicating when and by whom the release of patient medical records is permitted.

(5) Ensure that all utilization review business operations are reasonably secured during non-business hours.

(6) Require all employees with access to patient medical records to sign a confidentiality statement, to be maintained on file by the company, in which the employee acknowledges the confidential nature of such information.

(7) Maintain a written policy stipulating sanctions for an employee’s unauthorized disclosure of patient medical records, up to and including termination of employment.

(8) Maintain procedures for limiting access to computer files containing patient medical records through passwords, restricted functions and computer terminal security.

(9) Develop and maintain procedures to address the security of all patient medical records that are transferred by facsimile, which shall include:

(i) A statement in all facsimile transmission cover sheets that such data is confidential and is limited specifically for use by the company in making a utilization review determination; and

(ii) Security procedures governing the use of facsimile transmissions, specifying restricted access to such transmissions, the extent of such information that may be released, and the placement of the facsimile machine in a reasonably secured or isolated area.

(b) Summary and aggregate data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

(Effective September 4, 2012)

Sec. 38a-591-4. Recordkeeping

With respect to all utilization reviews, urgent care or expedited utilization reviews, grievances of adverse determinations, and expedited reviews of adverse determinations, each utilization review company shall maintain an audit trail, through a written control log or computer report, clearly evidencing:

(1) the date that a request or grievance was received;

(2) the dates and reasons for any subsequent requests for additional information required to complete any such review or grievance;

(3) the dates of the receipt of the additional information; and

(4) the date of notification to the provider of record or the covered person or the covered person's authorized representative.

(Effective September 4, 2012)

Sec. 38a-591-5. Statistical reporting to the commissioner

(a) Each health carrier shall file annually with the commissioner, on or before March 1, a summary report of its utilization review program activities in the calendar year immediately preceding and a report that includes for each type of health benefit plan offered by the health carrier the required information set forth in subsection (e)(1)(B) of section 38a-591b of the Connecticut General Statutes.

(b) Each health carrier shall report the information indicated in a format as specified annually by the commissioner and shall maintain source records adequate to support the accuracy of the information filed.

(Effective September 4, 2012)

Sec. 38a-591-6. Examinations

(a) The commissioner may undertake a compliance examination of any utilization review company licensed and conducting business in this state. In conducting the examination, the commissioner or his designee may examine the offices of such utilization review company, its books, records, procedures and any other information deemed to be relevant to the examination.

(b) Upon completing the compliance examination, the commissioner or his designee shall issue a report of the examination. The report shall include any corrective or remedial actions deemed necessary to be taken by the utilization review company in order to assure compliance with the requirements of Connecticut law.

(Effective September 4, 2012)

Sec. 38a-591-7. Grievance procedures

(a) Each health carrier shall file with the commissioner a copy of the written procedures, including all forms used to process requests, for (1) the review of grievances of adverse determinations that were based, in whole or in part, on medical necessity, (2) the expedited review of grievances of adverse determinations of urgent care requests, including concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services but has not been discharged from a

facility, and (3) notifying covered persons or covered persons' authorized representatives of such adverse determinations.

(b) Each health carrier shall file with the commissioner an initial copy of such procedures, including all forms used to process requests, no later than September 1, 2012 and any subsequent material modifications to such procedures no later than one month following implementation of the modification.

(Effective September 4, 2012)

Sec. 38a-591-8. Notice to enrollees

(a) Each health carrier that submits notices to a covered person or the covered person's authorized representative pursuant to section 38a-591d of the Connecticut General Statutes, including adverse determinations that involve a rescission, shall include with the Notice of Adverse Determination a description of the health carrier's procedures for initiating an internal grievance of an adverse determination including the procedures for requesting an expedited review. Such notification shall also include the procedures for filing an external review and an expedited external review.

(b) Each health carrier that submits a notice to a covered person or the covered person's authorized representative pursuant to section 38a-591e of the Connecticut General Statutes shall include with the Notice of a Grievance Decision that upholds the adverse determination a description of the health carrier's procedures for initiating any remaining internal grievance rights including the procedures for requesting an expedited review. If the Notice of a Grievance Decision that upholds the adverse determination is the final adverse determination, or if the notice is issued due to the health carrier's failure to strictly adhere to the requirements of section 38a-591e(f)(1) of the Connecticut General Statutes, the notice shall also include a statement that all internal appeals have been exhausted. Such notice shall include the procedure for filing an external review and an expedited external review, as well as a copy of the external review application and a consumer guide to the external review process. The commissioner shall develop and make available to health carriers the external review application and consumer guide to the external review process. A copy of the external review application and consumer guide shall also be made available from the health carrier to a covered person or the covered person's authorized representative, upon request.

(Effective September 4, 2012)

Sec. 38a-591-9. Rescission notice

Health carriers shall provide advance written notice, consistent with 45 C.F.R. 136, to each covered person who would be affected before coverage may be rescinded regardless of whether the rescission applies to an entire group or only to an individual within the group.

(Effective September 4, 2012)

Sec. 38a-591-10. Independent review organizations

(a) The commissioner shall enter into agreements for external review services with as many independent review organizations as he deems necessary. The agreements shall set forth all terms which the commissioner deems necessary to assure a full and fair review.

(b) After entering into an agreement with the commissioner, an independent review organization shall report changes in its ownership, or its operational or administrative status to the commissioner not later than thirty (30) days after the effective date of such change. If the commissioner determines that the reported

change(s) may negatively impact the effectiveness or objectivity of the independent review organization, the commissioner may terminate the agreement.

(Effective September 4, 2012)

Sec. 38a-591-11. Severability

If any provision of sections 38a-591-1 to 38a-591-11, inclusive, of the Regulations of Connecticut State Agencies or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the provisions of said regulations, and the application of such provision to other persons or circumstances shall not be affected thereby.

(Effective September 4, 2012)

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Approval of Form of Fraternal Benefit Society Policies and Contracts

Sec. 38a-640-1. Definitions

As used in this regulation:

- (a) "Commissioner" means the Insurance Commissioner of this state.
 - (b) "Form" means a certificate or other evidence of a contract of accident insurance or health insurance or of a total and permanent disability contract, or application, rider or endorsement used in connection therewith.
 - (c) "Society" means a fraternal benefit society as defined in Section 38a-595 of the General Statutes.
- (Effective September 25, 1992)

Sec. 38a-640-2. Filing procedure

Any society required pursuant to Section 38a-640 of the General Statutes to file a copy of a form with the Commissioner for approval, shall comply with the following standards:

(a) Filing Transmittal Letter.

(1) The filing transmittal letter should be sent to the attention of the Life and Health Division of the Insurance Department.

(2) The filer shall enclose a return copy of the transmittal letter(s) along with a stamped self-addressed return envelope of a size sufficient to return the duplicate copies of the filing to the society, and one letter size self-addressed stamped envelope to provide the notice required by Section 38a-640-3 (a).

(3) The filing transmittal letter shall contain a descriptive caption. The caption shall identify the society and include a brief description of the type of filing, and any applicable form identification number. All subsequent correspondence to the Insurance Department on the filing shall include the caption in the identical form as it was displayed in the original filing transmittal letter, in addition to the date of the original filing transmittal letter (and the Department's file number, if known).

(4) The body of the filing transmittal letter shall list the documents submitted therewith, briefly outline proposed changes, the approval sought, and specify the proposed effective date. When the form(s) sought to be approved by the Commissioner are not subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, the filing transmittal letter shall disclose such fact.

(5) The society shall provide in the filing transmittal letter a telephone number for readily contacting the person responsible for submitting the filing.

(b) All forms filed with the Insurance Department in accordance with this section shall be filed in duplicate. All such filings must be submitted in a clearly legible condition.

(c) All form filings shall include a separate document for the disclosure of the intended use of the form and the method it will be marketed. Such disclosure document, which will delimit the scope of the Commissioner's approval of the form, shall contain in numerical sequence the following:

- (1) Information on exactly how the form will be marketed;
- (2) The market for which the form is intended (such as markets consisting of individuals over age 65);
- (3) The underwriting basis used, note especially any deviation from standard underwriting rules (medical, non-medical, guaranteed issue, simplified application, etc.);

- (4) Any limitation of the use of the form by certain agents or brokers;
 - (5) An explanation of any change in benefits which occur while the contract is in force with a reference to the contract provisions which relate to the benefit change;
 - (6) For individual forms, disclosure of whether the commissions and gross premium rates are consistent with those of the society's individual policies. If the assumptions underlying the premium rates differ from the society's regular individual policies, an explanation shall be given of the difference, and the reason that use of the form does not result in unfair discrimination;
 - (7) A notation and explanation of any deviation from the society's usual retention; and
 - (8) Any additional information which may be necessary to completely understand the form and its use in this state.
- (d) Every form filing shall be completed in "John Doe" fashion.
- (e) (1) Every form filing subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, shall be accompanied with a certificate signed by an officer of the society, that the form complies with the Insurance Plain Language Act.
- (2) The certificate required by subdivision (1) of this subsection shall be in the following form:

(NAME OF COMPANY)

(COMPANY ADDRESS)

This is to certify that the forms listed below are in compliance with Chapter 699a of the Connecticut General Statutes.

A. Option Selected

- _____ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____.
- _____ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:

Form	Form Number	Flesch Score
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B. Test Option Selected

- _____ 1. Test was applied to entire policy form(s)
- _____ 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. Standards for Certification

- A checked block indicates the standard has been achieved.
- _____ 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.
 - _____ 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)
 - _____ 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.
 - _____ 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.
 - _____ 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

_____ 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsement or riders.

_____ 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

(SOCIETY NAME)

_____ By: _____
 (Date) (Title)

(f) Each form filing shall be accompanied with the rates that will be used in connection with such form.

(g) When a society makes reference to another document in its filing, it must include a copy and fully disclose the referenced document.

(h) The Insurance Department is obligated to collect, pursuant to Section 38a-11 (b) of the General Statutes, form filing fees from foreign or alien societies, if the state in which they are domiciled imposes such (and larger) fees upon Connecticut's domestic societies. Accordingly, each society domiciled in any other state which requires such fees shall remit the equivalent filing fee (in the form of a check made payable to the Treasurer, State of Connecticut) together with each such filing submitted. The society shall also represent and certify that the fee payment remitted is the same amount required by its domiciliary state or jurisdiction.

(Effective September 25, 1992)

Sec. 38a-640-3. Policy form approval

(a) Within fifteen (15) days of receipt of a form filed with the Commissioner for approval pursuant to Section 38a-640 of the General Statutes, the Insurance Department shall determine a filing to be complete or deficient for purposes of submission for review and shall issue written notice to the society regarding the status of the form.

(1) The written notice for a complete filing shall state that the form filing is complete and accepted for filing for review as of the date of its receipt. For purposes of this section, a form filing is complete upon agency determination that it is in compliance with Section 38a-640-2.

(2) The written notice for a deficient filing shall state that the form filing is deficient and not accepted for filing and shall set out the specific items that must be corrected to make the form complete. In addition to this notice, the Insurance Department may notify the society, in any manner, of problems with the form.

(b) Unless otherwise provided by law, the Insurance Department shall review all forms filed with the Insurance Commissioner for approval pursuant to Section 38a-640 of the General Statutes in the order in which they are received by the Department; provided, however, that in appropriate circumstances the Commissioner may waive this requirement and direct the immediate review of a form filing. The Department shall employ a chronological logging system to facilitate the chronological review of such forms.

(c) Within seventy-five (75) days after a form is accepted for review, the Insurance Department shall review the form and either approve it or disapprove it. If, upon such review of the form, the Insurance Department determines that additional information from the society is necessary in order to ascertain whether the form is

contrary to law, the Department shall make such request to the society. The society will then have thirty (30) days from the date of the request to provide the Department with the additional information; provided that during such time, the society may request in writing that the period for responding to the request for information be extended for an additional period of time, not to exceed sixty (60) days. The request for extension shall be considered granted upon its receipt by the Insurance Department. During the pendency of the Insurance Department's request for information, the seventy-five (75) day period for Department action shall be tolled. If the society fails to comply with such request within the allotted time, the society shall be deemed to have voluntarily withdrawn its filing and the Department shall close its file without further action.

(d) The Commissioner shall issue an order disapproving the use of any such form if it does not comply with the requirements of law. Any such order shall specify the reason for disapproval of the form.

(e) Forms that are approved by the Commissioner shall have the form and the extra copy of the filing transmittal letter stamped "Approved," together with the name and signature of the staff member who acted upon the filing and the date of the approval.

(Effective September 25, 1992)

Sec. 38a-640-3a. Electronic filing

(a) Any society filing a copy of a form with the commissioner in accordance with section 38a-640-2 of the Regulations of Connecticut State Agencies may submit such form electronically using software known as the System for Electronic Rate and Form Filing (SERFF), Version 2.0 or higher, or any subsequent corresponding system, adopted by the National Association of Insurance Commissioners. All such filings shall include the information required in section 38a-640-2 of the Regulations of Connecticut State Agencies.

(b) Filings made electronically shall be considered received by the commissioner when received at the Insurance Department. Filings received on a weekend or legal holiday shall be deemed received on the next business day. An electronic communication from the Insurance Department concerning a filing shall be deemed received by the person to whom the communication is addressed when the communication is sent to that person.

(Adopted effective January 2, 2002)

Sec. 38a-640-4. Severability

If any provision of this regulation or 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.

(Effective September 25, 1992)

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Approval of Credit Life Insurance and Credit Accident and Health Insurance Policy Forms

Sec. 38a-651-1. Definitions

As used in this regulation:

- (a) “Commissioner” means the Insurance Commissioner of this state.
 - (b) “Form” means a credit life insurance or credit accident and health insurance, policy or application, certificate, notice of proposed insurance rider or endorsement used in connection therewith.
 - (c) “Insurer” means an insurance company licensed by the Commissioner to write credit life insurance or credit accident and health insurance.
- (Effective September 25, 1992)

Sec. 38a-651-2. Filing procedure

Any insurer required pursuant to Section 38a-651 of the General Statutes to file a copy of a form with the Commissioner for approval, shall comply with the following standards:

(a) **Filing Transmittal Letter.**

(1) The filing transmittal letter should be sent to the attention of the Life and Health Division of the Insurance Department.

(2) If one or more elements within a filing vary by member company within a group of companies, the filer shall send a separate filing transmittal letter for each insurer within the group.

(3) The filer shall enclose a return copy of the transmittal letter(s) along with a stamped self-addressed return envelope of a size sufficient to return the duplicate copies of the filing to the insurer, and one letter size self-addressed stamped envelope to provide the notice required by Section 38a-651-3 (a).

(4) The filing transmittal letter shall contain a descriptive caption. The caption shall identify the insurer when the insurer is a member of an affiliated group of insurers using generic letterhead. The caption shall also include a brief description of the type of filing, and any applicable form identification number. All subsequent correspondence to the Insurance Department on the filing shall include the caption in the identical format as it was displayed in the original filing transmittal letter, in addition to the date of the original filing transmittal letter (and the Department’s file number, if known).

(5) The body of the filing transmittal letter shall list the documents submitted therewith, briefly outline proposed changes, the approval sought, and specify the proposed effective date. When the form(s) sought to be approved by the Commissioner are not subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, the filing transmittal letter disclose state such fact.

(6) The insurer shall provide in the filing transmittal letter a telephone number for readily contacting the person responsible for submitting the filing.

(b) All forms filed with the Insurance Department in accordance with this section shall be filed in duplicate. All such filings must be submitted in a clearly legible condition.

(c) All form filings shall include a separate document for the disclosure of the intended use of the form and the method it will be marketed. Such disclosure document, which will delimit the scope of the Commissioner’s approval of the form, shall contain in numerical sequence the following:

(1) Information on exactly how the form will be marketed (i.e. individual basis, mass merchandised, association membership, union membership etc.);

(2) The market for which the form is intended (especially note markets such as over age 65, key men, professionals, etc.);

(3) The underwriting basis used, note especially any deviation from standard underwriting rules (medical, non-medical, guaranteed issue, simplified application, etc.);

(4) Any limitation of the use of the form by certain agents or brokers;

(5) An explanation of any change in benefits which occur while the contract is in force with a reference to the contract provisions which relate to the benefit change;

(6) For individual forms, disclosure of whether the commissions and gross premium rates are consistent with those of the company's individual policies. If the assumptions underlying the premium rates differ from the insurer's regular individual policies, an explanation shall be given of the difference, and the reason that use of the form does not result in unfair discrimination;

(7) A notation and explanation of any deviation from the insurer's usual retention; and

(8) Any additional information which may be necessary to completely understand the form and its use in this state.

(d) Every form filing shall be completed in "John Doe" fashion.

(e) (1) Every form filing subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, shall be accompanied with a certificate signed by an officer of the insurer that the form complies with the Insurance Plain Language Act.

(2) The certificate required by subdivision (1) of this subsection shall be in the following form:

(NAME OF COMPANY)

(COMPANY ADDRESS)

This is to certify that the forms listed below are in compliance with Chapter 699a of the Connecticut General Statutes.

A. Option Selected

___ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is ___.

___ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:

Form	Form Number	Flesch Score
------	-------------	--------------

B. Test Option Selected

___ 1. Test was applied to entire form(s)

___ 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. Standards for Certification

A checked block indicates the standard has been achieved.

___ 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

___ 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)

____ 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

____ 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.

____ 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

____ 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsement or riders.

____ 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

(COMPANY NAME)

By: _____

(Date)

(Title)

(f) Each form filing shall be accompanied with the schedule of premium rates that will be used in connection with such form.

(g) The Insurance Department is obligated to collect, pursuant to Section 12-211 of the General Statutes, form filing fees from foreign or alien insurers, if the state or foreign country in which they are domiciled imposes such (and larger) fees upon Connecticut's domestic insurers. Accordingly, each insurer domiciled in any other state or jurisdiction which requires such fees shall remit the equivalent filing fee (in the form of a check made payable to the Treasurer, State of Connecticut) together with each such filing submitted. The insurer shall also represent and certify that the fee payment remitted is the same amount required by its domiciliary state or jurisdiction.

(Effective September 25, 1992)

Sec. 38a-651-3. Policy form approval

(a) Within fifteen (15) days of receipt of a form filed with the Commissioner for approval pursuant to Section 38a-651 of the General Statutes, the Insurance Department shall determine a filing to be complete or deficient for purposes of submission for review and shall issue written notice to the insurer regarding the status of the form.

(1) The written notice for a complete filing shall state that the form filing is complete and accepted for filing for review as of the date of its receipt. For purposes of this section, a form filing is complete upon agency determination that it is in compliance with Section 38a-651-2.

(2) The written notice for a deficient filing shall state that the form filing is deficient and not accepted for filing and shall set out the specific items that must be corrected to make the form complete. In addition to this notice, the Insurance Department may notify the insurer, in any manner, of problems with the form.

(b) Unless otherwise provided by law, the Insurance Department shall review all forms filed with the Insurance Commissioner for approval pursuant to Section 38a-651 of the General Statutes in the order in which they are received by the Department; provided, however, that in appropriate circumstances the Commissioner may waive this requirement and direct the immediate review of a form filing. The Department shall employ a chronological logging system to facilitate the chronological review of such forms.

(c) Within seventy-five (75) days after a form is accepted for review, the Insurance Department shall review the form and either approve it or disapprove it. If, upon such review of the form, the Insurance Department determines that additional information from the insurer is necessary in order to ascertain whether the form is contrary to law or is unfair, deceptive or may encourage misrepresentation of the policy, the Department shall make such request to the insurer. The insurer will then have thirty (30) days from the date of the request to provide the Department with the additional information; provided that during such time, the insurer may request in writing that the period for responding to the request for information be extended for an additional period of time, not to exceed sixty (60) days. The request for extension shall be considered granted upon its receipt by the Insurance Department. During the pendency of the Insurance Department's request for information, the seventy-five (75) day period for Department action shall be tolled. If the insurer fails to comply with such request within the allotted time, the insurer shall be deemed to have voluntarily withdrawn its filing and the Department shall close its file without further action.

(d) The Commissioner shall issue an order disapproving the use of any such form if the schedule of premium rates charged or to be charged is by reasonable assumptions excessive in relation to the benefits provided, or if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or which encourage misrepresentation of the coverage or which are contrary to any provision of the insurance laws or of any rule or regulation promulgated thereunder. Any such order shall specify the reason for disapproval of the form.

(e) Forms that are approved by the Commissioner shall have the form and the extra copy of the filing transmittal letter stamped "Approved," together with the name and signature of the staff member who acted upon the filing and the date of the approval.

(Effective September 25, 1992)

Sec. 38a-651-3a. Electronic filing

(a) Any insurer filing a copy of a form with the commissioner in accordance with section 38a-651-2 of the Regulations of Connecticut State Agencies may submit such form electronically using software known as the System for Electronic Rate and Form Filing (SERFF), Version 2.0 or higher, or any subsequent corresponding system, adopted by the National Association of Insurance Commissioners. All such filings shall include the information required in section 38a-651-2 of the Regulations of Connecticut State Agencies.

(b) Filings made electronically shall be considered received by the commissioner when received at the Insurance Department. Filings received on a weekend or legal holiday shall be deemed received on the next business day. An electronic communication from the Insurance Department concerning a filing shall be deemed received by the person to whom the communication is addressed when the communication is sent to that person.

(Adopted effective January 2, 2002)

Sec. 38a-651-4. Severability

If any provision of this regulation or 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.

(Effective September 25, 1992)

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Bail Bond Producers Application and Renewal

Sec. 38a-660-1. Definitions

As used in sections 38a-660-1 to 38a-660-7, inclusive:

- (1) "Commissioner" means the Insurance Commissioner;
- (2) "Education certificate" means the certificate from the educational facility authorized by the commissioner to conduct the Surety Bail Bond Agent prelicensing course evidencing satisfactory completion of such course;
- (3) "Felony" means felony as defined in subsection (a) of section 53a-25 of the general statutes;
- (4) "Individual producer application" means application form INS-301 of the State of Connecticut Insurance Department;
- (5) "Insurer" means any domestic, foreign or alien insurance company which has qualified generally to transact surety business in this state under the requirements of chapter 698 of the general statutes and specifically to transact bail bond business in this state;
- (6) "Misdemeanor" means misdemeanor as defined in subsection (a) of section 53a-26 of the general statutes;
- (7) "Passing grade score report" means the report provided by the testing service authorized by the Commissioner to test licensing applicants evidencing the grade score achieved on the Surety Bail Bond Agent licensing examination;
- (8) "Solicit" means solicit as defined in subsection (a)(5) of section 38a-660 of the general statutes;
- (9) "Surety bail bond agent" means surety bail bond agent as defined in subsection (a)(3) of section 38a-660 of the general statutes.

(Adopted effective March 21, 1997; amended February 1, 2000, December 6, 2000)

Sec. 38a-660-2. Initial application

(a) An applicant for a license as a surety bail bond agent shall submit to the Licensing Division of the Insurance Department:

- (1) an individual producer application;
- (2) a recent credential-sized full face photograph of the applicant;
- (3) the original education certificate;
- (4) the passing grade score report;
- (5) a copy of the applicant's birth certificate;
- (6) if a naturalized citizen, a copy of the applicant's naturalization papers; and
- (7) the initial license fees in accordance with section 38a-11 of the general statutes.

(b) The applicant shall also submit to the Bond Forfeiture Unit of the Office of the Chief State's Attorney:

- (1) a copy of the individual producer application complete with attachments prescribed in (a)(2) through (a)(6), inclusive, of this section; and
- (2) a complete set of the applicant's fingerprints, certified by an authorized law enforcement officer.

(Adopted effective March 21, 1997; amended February 1, 2000)

Sec. 38a-660-3. Renewal application

An applicant for the renewal of a license as a surety bail bond agent shall submit to the Licensing Division of the Insurance Department:

- (1) an application for renewal in a form prescribed by the Commissioner; and
- (2) the renewal license fees in accordance with section 38a-11 of the general statutes.

(Adopted effective March 21, 1997; amended February 1, 2000)

Sec. 38a-660-4. Company appointment

The applicant shall cause the insurer for whom the applicant is to execute undertakings of bail and to solicit and negotiate such undertakings on its behalf to submit to the Licensing Division of the Insurance Department an individual application for appointment together with the appointment application filing fee in accordance with section 38a-11 of the general statutes.

(Adopted effective March 21, 1997; amended February 1, 2000)

Sec. 38a-660-5. Additional insurer appointments

A licensed surety bail bond agent applying to execute undertakings of bail on behalf of an additional insurer for which such agent is not currently appointed shall cause such insurer to submit to the Licensing Division of the Insurance Department an individual application for appointment together with the appointment application filing fee in accordance with section 38a-11 of the general statutes.

(Adopted effective March 21, 1997; amended February 1, 2000)

Sec. 38a-660-6. Disqualification

(a) Any person who has been convicted of a felony shall not qualify for a bail bond agent's license.

(b) Any person who has been convicted of a misdemeanor under Section 21a-279, 53a-58, 53a-61, 53a-61a, 53a-62, 53a-63, 53a-96, 53a-173, 53a-175, 53a-176, 53a-178 or 53a-181d of the general statutes shall not qualify for a surety bail bond agent license.

(c) The surety bail bond agent license of any person shall be automatically canceled upon conviction of a felony or any misdemeanor under Section 21a-279, 53a-58, 53a-61, 53a-61a, 53a-62, 53a-63, 53a-96, 53a-173, 53a-175, 53a-176, 53a-178 or 53a-181d of the general statutes.

(Adopted effective March 21, 1997; amended February 1, 2000, December 6, 2000)

Sec. 38a-660-7. Convictions

Applicants for a surety bail bond agent license who have been convicted of a misdemeanor other than a misdemeanor under Sections 21a-279, 53a-58, 53a-61, 53a-61a, 53a-62, 53a-63, 53a-96, 53a-173, 53a-175, 53a-176, 53a-178 or 53a-181d of the general statutes and are not otherwise disqualified from being licensed shall submit to the Licensing Division of the Insurance Department proof of the applicant's conviction, release from imprisonment, and release from parole or probation.

(Adopted effective March 21, 1997; amended February 1, 2000, December 6, 2000)

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Approval of Property & Casualty Insurance Forms

Sec. 38a-676-1. Definitions

As used in Sections 38a-676-1 through 38a-676-3, inclusive:

(a) “Commissioner” means the Insurance Commissioner of this state.

(b) “Form” means any insurance policy or contract, other than fidelity, surety or guaranty bonds, and any endorsement modifying such policy or contract providing personal risk insurance or commercial risk insurance as defined in Section 38a-663 of the General Statutes.

(c) “Insurer” means an insurance company licensed by the Commissioner to write property and casualty insurance, or a licensed rating or advisory organization.

(d) “SERFF” means software known as the System for Electronic Rate and Form Filing, Version 2.0 or higher, or any subsequent corresponding system, adopted by the National Association of Insurance Commissioners.

(Effective September 25, 1992; amended January 2, 2002)

Sec. 38a-676-2. Filing procedure

Any insurer required pursuant to Section 38a-676 of the General Statutes to file a copy of a form with the Commissioner shall comply with the following standards:

(a) All filings of proposed policies, forms, endorsements or changes shall be submitted in an easily readable condition. Printer’s proofs, typewritten or photostatic copies, electronic filings submitted in accordance with subsection (g) of this section, or other legible copies are permitted. Only one copy of the filing is required to be filed and shall be retained by the Insurance Department; however, where an insurer wishes to have a complete copy of the filing and the transmittal letter returned to it, filings in duplicate are permissible.

(b) Filing Transmittal Letter.

(1) The filing transmittal letter should be sent to the attention of the Property and Casualty Division of the Insurance Department.

(2) If one or more elements within a filing vary by member company within a group of companies, the filer shall send a separate filing transmittal letter for each insurer within the group.

(3) The filer shall enclose a return copy of the transmittal letter along with a stamped self-addressed return envelope of a size sufficient to return either the copy of the transmittal letter or the copy of the entire filing and transmittal letter if the insurer has elected to file a duplicate copy of the filing in accordance with Section 38a-676-2 (a). Additionally, the insurer must enclose a letter sized self-addressed stamped envelope to provide the notice required by Section 38a-676-3 (a).

(4) The filing transmittal letter shall contain a descriptive caption. The caption shall: (i) identify the insurer; (ii) briefly identify the line of insurance or program to which the filing pertains; (iii) include a brief description of the purpose of the filing; (iv) where the insurer maintains a filing numbering system, list its filing number; (v) include its assigned National Association of Insurance Commissioners’ insurer code number which includes the group code number and company code number. If more than one company is included in the filing show each company code number.

All subsequent correspondence to the Insurance Department concerning the filing shall include the caption in the identical format as it was displayed in the original filing transmittal letter and, in addition, the date of the original filing transmittal letter.

(5) The body of the filing transmittal letter shall specify the proposed effective date and provide the name and telephone number for contacting the person responsible for submitting the filing.

(c) **Explanatory Memorandum.** Except as provided in subdivision (2) of this subsection, each filing shall include an explanatory memorandum describing the filed changes.

(1) If the filed form is new or a replacement of a currently filed form, as opposed to a revision of a currently filed form, then the explanatory memorandum must describe each element of the form.

(2) If the filed form is a revision of a currently filed form then the explanatory memorandum shall describe each element of the filed changes. Such memorandum shall include a comparison of the new wording with the wording being replaced or, in lieu of this, bracketing [] the words or matter (e.g. numbers) in a filing to be omitted and underlining the words or matter to be added on a copy of the form itself. The filing of a revised form or forms must fully describe the intent and reasonably anticipated effect(s) of each element of the revision. If the filing consists of a minor revision to a form, the filer may, in lieu of an explanatory memorandum, provide the information required by this subdivision in the body of the transmittal letter.

(3) In all instances list the title of the form(s) submitted therewith along with the form identification number(s) and edition date, if any. Indicate any previously filed forms to be withdrawn, along with the form identification number(s) and edition date, if any.

(4) If less than five (5) forms are being filed at one time, the filer may, in lieu of providing this information on the explanatory memorandum, include it in the transmittal letter.

(5) All filings that incorporate by reference a rating or advisory organization document must include the name of the organization and the reference document number. All filings that adopt a form promulgated by a rating or advisory organization may in lieu of a reference document number indicate the document form number and revision date, if applicable. Failure to supply this information will render the filing incomplete and will be returned to the filer with the appropriate notation.

(d) In accordance with chapter 699a of the General Statutes, concerning readable language in insurance policies, certain insurance policies and policy forms issued or delivered in this state shall meet simplified language standards. The property and casualty policies affected are: Individual personal line dwelling coverage on one to four family units, personal inland marine, and personal line automobile insurance. Personal line automobile insurance includes coverage for vehicles designed primarily for personal, family or household needs.

Every such form filing shall be accompanied by a certificate signed by an officer of the insurer, in the format specified by the Insurance Department, that such form complies with Chapter 699a of the General Statutes. See Appendix I. If a form filing is submitted electronically in accordance with subsection (g) of this section, the original signed certification shall be maintained by the insurance company and available for inspection by the Insurance Department.

(1) A separate certification shall be submitted for each policy and its related endorsements. Certification may be accomplished by using a policy and its related forms as one unit or each policy and each form separately.

(2) Certifications shall be submitted on a replica of the one shown in Appendix I and will apply only to the policies and endorsements listed on the certification form.

(3) Future revisions of policies or endorsements which have been previously certified shall be recertified. In each case, a replica of the sample certification form (Appendix I of this Regulation) shall be used.

(4) Individual companies or groups of companies may certify policies and endorsements filed by the company or group.

(e) The Insurance Department is obligated to collect, pursuant to Section 12-211 of the General Statutes, form filing fees from foreign or alien insurers, if the state or foreign country in which they are domiciled imposes such (and larger) fees upon Connecticut's domestic insurers. Accordingly, each insurer domiciled in any other state or jurisdiction which requires such fees shall remit the equivalent filing fee (in the form of a check made payable to the Treasurer, State of Connecticut) together with each such filing submitted. The insurer shall also represent and certify that the fee payment remitted is the same amount required by its domiciliary state or jurisdiction. No filing submission will be accepted unless the filing fee is also received by the Insurance Department.

(f) Any employee of an insurer may submit a filing on behalf of the insurer, provided that the filing is described upon the insurer's official stationery or is submitted electronically in accordance with subsection (g) of this section. Filings which are submitted on behalf of an insurer by a licensed rating or advisory organization will be accepted only if the Insurance Department has on file a currently effective filing authorization which is certified by an officer of the insurer. Such an authorization must clearly indicate the extent of the licensed rating or advisory organization's filing authority to act on behalf of the insurer. Unless the authorization contains an expiration date, it will be considered valid until withdrawn in writing by an officer of the insurer.

(g) Insurance companies, rating and advisory organizations may submit the rate form or other filings electronically using SERFF.

(h) The time limit for the commissioner to act on filings made electronically shall be the same as the time limit for the commissioner to act on filings made in paper form. Filings made electronically shall be considered received by the commissioner when received in the electronic data processing system used by the commissioner to review filings, unless received on a weekend or legal holiday, in which case filings are deemed received on the next business day. Communications from the commissioner to persons making filings electronically shall be considered received by that person when the communication is sent electronically to the person making the filing.

(Effective September 25, 1992; amended January 2, 2002)

Sec. 38a-676-3. Policy form acceptance

(a) Within fifteen (15) calendar days of receipt of a form filed with the Commissioner pursuant to Section 38a-676 of the General Statutes, the Insurance Department shall determine a filing to be complete or deficient for purposes of submission for review and shall issue written notice to the insurer regarding the status of the form.

(1) The written notice for a complete filing shall state that the form filing is complete and accepted for review as of the date of its receipt. For purposes of this section, a form filing is complete upon the Insurance Department's determination that it is in compliance with Section 38a-676-2.

(2) The written notice for a deficient filing shall state that the form filing is deficient and not accepted for filing and shall set out the specific items that must be corrected to make the form complete. In addition to this notice, the Insurance

Department may notify the insurer, in any manner, of any additional problems with the form.

(b) Unless otherwise provided by law, the Insurance Department shall review all forms filed with the Insurance Commissioner pursuant to Section 38a-676 of the General Statutes in the order in which they are received by the Insurance Department; provided, however, that when exceptional circumstances exist, the Commissioner may direct the immediate review of a form filing. The Insurance Department shall employ a chronological logging system to facilitate chronological review. The Insurance Department may make an exception to the chronological order where it deems it appropriate to do so.

(c) Within thirty (30) calendar days after a form is accepted for review, the Insurance Department shall review the form and either record it effective or disapprove it. If, upon such review of the form, the Insurance Department determines that additional information from the insurer is necessary in order to ascertain whether the form is contrary to law or is unfair, deceptive or may encourage misrepresentation of the policy, the Insurance Department shall make such request to the insurer. The insurer will then have thirty (30) calendar days from the date of the request to provide the Insurance Department with the additional information, provided that during such time, the insurer may request in writing that the period for responding to the request for information be extended for an additional period of time, not to exceed an additional sixty (60) calendar days. The request for an extension shall be considered granted upon its receipt by the Insurance Department. During the pendency of the Insurance Department's request for information, the thirty (30) day period for Insurance Department action shall be tolled. If the insurer fails to comply with such request within the allotted time, such applicant shall be deemed to have voluntarily withdrawn its filing and the Insurance Department shall close its file without further action.

(d) The Commissioner shall disapprove the use of any such form if it does not comply with the provisions of this regulation or any other provision of law, or if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy. Any such action shall specify the reason for disapproval of the form.

(e) Forms that are not disapproved by the Commissioner shall have the extra copy of the filing transmittal letter returned stamped "Recorded Effective" with the effective date of the filing, the name and signature of the staff member who acted upon the filing and the date the filing was stamped.

(Effective September 25, 1992)

(See Appendix on following pages)

APPENDIX I

STATE OF CONNECTICUT
 POLICY AND ENDORSEMENT CERTIFICATION FORM
 AS PER CHAPTER 699a OF THE GENERAL STATUTES
 (READABLE LANGUAGE)
 PART A

Name of Company or Group _____

Certification applies to: _____
 (Company) (Group)

(If certification is made on behalf of a Group of Companies, indicate names of all companies with Group below).

COMPLETE EACH APPLICABLE BOX BELOW
 OR INDICATE NOT APPLICABLE (N.A.)

Form is filed by:

Company/Group has the following Policy/Form on file in Connecticut	Indicate Program Name	(Indicate filer by name: rating organization, advisory organization, company)*
Homeowners	_____	_____
Dwelling Fire	_____	_____
Personal, Inland Marine	_____	_____
Personal Auto	_____	_____
Motorcycle	_____	_____
Recreational Vehicle	_____	_____

(* For each policy or endorsement indicated as filed by the Company, it is required that the (*) Company complete Part B of the Policy and Endorsement Certification Form.

The company certifies that the above forms filed by the Company or on its behalf and the forms shown on Part B of the Policy and Endorsement Certification Form, meet the minimum standards of readability required by Chapter 699a of the General Statutes and the letter height requirement of regulation 38a-297-3. The type-face style(s) used for the above forms is (are):

Signed _____

Title _____
 (Officer of the Company)

Date _____

STATE OF CONNECTICUT
POLICY AND ENDORSEMENT CERTIFICATION FORM
AS PER CHAPTER 699a OF THE GENERAL STATUTES
(READABLE LANGUAGE)
PART B

Name of Company or Group _____

As certified by an officer of the company on Part A, the policy and the related endorsements listed below comply with the minimum standards of readability required by Chapter 699a of the General Statutes and the letter height requirement of regulation 38a-297-3.

Options (Check One)

“Sample” technique can be used only if policy or endorsement contains more than 10,000 words. A copy of policy or endorsement highlighting word samples tested must be attached.

1. Policy and related forms are scored for the Flesch reading ease test as one unit. Companies using the standard Connecticut Basic Reparations Benefits endorsement which has not yet been simplified may exclude this endorsement in the determination of the combined score if they so indicate.
2. Policy and related endorsements are separately scored for Flesch reading ease test.

Policy or Endorsement

Form No.

(Effective September 25, 1992)

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**An Accident Prevention Course for Operators Who
Have Attained the Age of Sixty Years**

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An Accident Prevention Course for Operators Who Have Attained the Age of Sixty Years

Sec. 38a-683-1. Purpose

Section 38a-683-2, section 38a-683-4, section 38a-683-6 and section 38a-683-7 of the Regulations of Connecticut State Agencies are intended to comply with section 38a-683(b) of the Connecticut General Statutes, concerning the course content and other requirements of an accident prevention course for operators who have attained the age of sixty years.

(Effective September 25, 1992; amended May 8, 2006, December 21, 2009)

Sec. 38a-683-2. Definitions

Terms used in this regulation shall have the following meanings:

- (1) "Commissioner" means the Commissioner of Motor Vehicles.
- (2) "School" means an organization or agency that conducts an accident prevention course.
- (3) "Instructor" means an individual who has been trained and appointed by a school for the purpose of conducting an approved classroom accident prevention course.

(4) "Classroom Accident Prevention Course" means an accident prevention program approved by the commissioner which meets the needs of an operator who has attained the age of sixty years and is conducted in a classroom setting.

(5) "Internet Accident Prevention Course" means an accident prevention program approved by the commissioner which meets the needs of an operator who has attained the age of sixty years and is offered on the Internet.

(6) "Certificate" means a document or form issued to all persons who have completed an approved accident prevention course.

(Effective September 25, 1992; amended May 8, 2006, December 21, 2009)

Sec. 38a-683-3.

Repealed, May 8, 2006.

Sec. 38a-683-4. Classroom accident prevention course approval

- (1) Provide, but need not be limited to, seven hours of classroom instruction;
- (2) Include instruction in problems that confront the operator who has attained the age of sixty years relative to driving frustrations and effects of aging on individual driving behavior;
- (3) Include instruction in the effects of alcohol, drugs or other medication on one's capabilities;
- (4) Include instruction in current accident prevention measures, e.g., proper following techniques and handling unexpected driving emergencies;
- (5) Include instruction in other subject areas including risk acceptance and one's personality as it affects driving, and perceptual problems likely to be encountered in various driving environments; and
- (6) Use only those instructors who have been trained and appointed for the purpose of conducting an approved accident prevention program.

(Effective September 25, 1992; amended May 8, 2006, December 21, 2009)

Sec. 38a-683-4a. Internet accident prevention course approval

An accident prevention course offered on the Internet for operators who have attained the age of sixty years shall be submitted to the commissioner for approval. To be approved, an accident prevention course, offered on the Internet for operators

who have attained the age of sixty years, shall meet the requirements established in this section:

(a) The content of a course offered on the Internet shall include the following:

(1) Instruction in problems that confront the operator who has attained the age of sixty years relative to driving frustrations and effects of aging on individual driving behavior;

(2) Instruction in the effects of alcohol, drugs or other medication on one's capabilities;

(3) Instruction in current accident prevention measures, e.g., proper following techniques and handling unexpected driving emergencies; and

(4) Instruction in other subject areas including risk acceptance and one's personality as it affects driving, and perceptual problems likely to be encountered in various driving environments.

(b) The procedure for administering such course offered on the Internet shall include the following:

(1) methods to ensure verification of the course enrollee's identity at the time of registration and throughout the duration of such course;

(2) methods to ensure verification of the participation of the course enrollee throughout the duration of such course;

(3) methods to ensure verification of the completion of such course by the course enrollee within thirty (30) days of his/her registering for such course; and

(4) methods to ensure verification of the successful completion of such course by the enrollee.

(c) The commissioner may periodically review the administration of the course offered on the Internet to determine its compliance with the requirements of subsections (a) and (b) of this section. If the commissioner finds that the content of such course or the procedure for administering such course has not satisfied the requirements of the original approval, he or she may mandate that modifications be made to maintain approval.

(Adopted effective December 21, 2009)

Sec. 38a-683-5.

Repealed, May 8, 2006.

Sec. 38a-683-6. Certificate of accident prevention course completion

(a) Each participant successfully completing an approved accident prevention course shall be issued a certificate of course completion, which shall include the following information:

(1) Name of student;

(2) Student's date of birth;

(3) Student's address;

(4) Date of accident prevention course completion;

(5) Name of school;

(6) If the course is presented in a classroom, the instructor's signature or ID number;

(7) If the course is presented on the Internet, and requires a final examination, the signature or ID number of the school representative administering the final examination, in a classroom setting, to the individual who has successfully completed the approved Internet accident prevention course; and

(8) If the course is presented on the internet, any information in addition to the applicable requirements of this subsection, that the commissioner may require as a

condition of his course approval, as provided for in section 38a-683-4a of the Regulations of Connecticut State Agencies.

(b) A certificate of accident prevention course completion shall be submitted to the commissioner for approval prior to its use. No school shall use any form which has not been approved.

(Effective September 25, 1992; amended May 8, 2006, December 21, 2009)

Sec. 38a-683-7. Withdrawal of approval

Any approval may be withdrawn or denied in the event the minimum requirements of sections 38a-683-1 to 38a-683-7, inclusive, of the Regulations of Connecticut State Agencies are not maintained. No approval of any accident prevention course shall be withdrawn without first providing an opportunity for a hearing as provided for in section 4-177 of the Connecticut General Statutes.

(Effective September 25, 1992; amended May 8, 2006)

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Territorial Rating System for Automobile Insurance

Sec. 38a-686-1. Definitions

As used in Sections 38a-686-1 to 38a-686-3, inclusive, of the Regulations of Connecticut State Agencies:

- (1) "Adopted statewide rate level change" means the premium weighted average of all base rate level changes.
- (2) "Antique, rare or special interest motor vehicle" has the same meaning as provided in section 14-1 of the Connecticut General Statutes.
- (3) "Base rate" means the benchmark premium rate for each territory.
- (4) "Classification system" or "classification" means the process of grouping risks with similar risk characteristics so that differences in costs may be recognized.
- (5) "Commissioner" means the Insurance Commissioner of the State of Connecticut.
- (6) "Credibility" means a measure of actuarial predictability assigned to a body of loss experience for private passenger nonfleet automobile insurance.
- (7) "Department" means the Connecticut Insurance Department.
- (8) "Exposure unit" means one private passenger nonfleet automobile insured for a twelve month period.
- (9) "Insurer" has the same meaning as provided in section 38a-1 of the Connecticut General Statutes.
- (10) "Rating organization" has the same meaning as provided in section 38a-663 of the Connecticut General Statutes.
- (11) "Advisory organization" has the same meaning as provided in section 38a-663 of the Connecticut General Statutes.
- (12) "Indicated statewide rate level change" means the premium weighted average of the indicated base rate changes.
- (13) "Indicated loss costs" means the expected loss costs per exposure unit based on actuarially adjusted historical loss data.
- (14) "Loss costs" means the portion of the premium that is applicable solely to loss, without provision for insurer, rating organization or advisory organization expenses or profits.
- (15) "Private passenger nonfleet automobile insurance policy" means an insurance policy issued for one or more private passenger nonfleet automobiles. "Private passenger nonfleet automobile insurance policy" does not include insurance policies for motorcycles, recreational vehicles or antique, rare or special interest motor vehicles.

(Effective January 30, 2012)

Sec. 38a-686-2. Private passenger nonfleet automobile insurance rate filings

(a) **Standards for the Establishment of Territorial Classifications.** In order to create a classification system for rating private passenger nonfleet automobile insurance risks, an insurer, rating organization or advisory organization may group risks by geographical territories composed of one or more unique town codes. An insurer, rating organization or advisory organization may use the United States Postal Service ZIP Codes corresponding to the unique town codes to determine the territory of garaging for private passenger nonfleet automobile individual risks. An insurer, rating organization or advisory organization shall not split a town or city into two or more geographical territories if more than one ZIP Code is ascribed to the particular town or city. If a street, road or similar geographic unit divides two geographically configured rating territories, an insurer, rating organization or advisory organization may split the territory into two or more geographical territories.

sory organization shall rate the particular risk using the lower rate of the two territories. An insurer, rating organization or advisory organization shall include a complete description of each geographical territorial configuration used in its rating plan filing.

(b) **Territorial Rate Filing Procedures.** An insurer, rating organization or advisory organization's geographical rating territories and any amendments to such geographical rating territories shall be filed with the Department and shall be subject to the Department's review and approval prior to their use. The Department shall disapprove any rating territory that does not conform to the requirements of this regulation.

(c) **Territorial Rate Filing Information.** Prior to an insurer, rating organization or advisory organization adopting and implementing a classification system that uses ZIP Codes to establish geographical rating territories, an insurer, rating organization or advisory organization shall file with the Department a copy of the classification system with the following information: (1) a table of each ZIP Code and its corresponding geographical rating territory; (2) a supplementary list of those ZIP Codes that overlap two or more rating territories; (3) an explanation of how the proposed rating system identifies the ZIP Code of the place of garaging versus the mailing address; (4) an explanation of how the proposed classification system will take into account changes in ZIP Code configurations as they occur; and (5) an alphabetical listing of the current one hundred sixty-nine Connecticut towns with a territory code assigned to each.

(d) **Territorial Loss Costs Weighting Procedures.** In computing an individual territorial base rate, an insurer, rating organization or advisory organization shall moderate indicated loss costs data with reference to the insurer, rating organization or advisory organization's statewide average loss costs by weighting the territorial indications with the statewide average as provided in subdivision (4) of subsection (b) of section 38a-686 of the Connecticut General Statutes.

(e) **Credibility.** In accordance with sound actuarial principles, an insurer, rating organization or advisory organization shall apply credibility procedures separately from the weighting procedures set forth in subdivision (4) of subsection (b) of section 38a-686 of the Connecticut General Statutes. An insurer, rating organization or advisory organization shall not use credibility adjustment procedures as a substitute for such weighting procedures in the ratemaking process. An insurer, rating organization or advisory organization shall use and apply the weighting procedures in addition to credibility adjustments.

(f) **Classification Factors.** An insurer, rating organization or advisory organization may group risks by classifications for the establishment of rates and minimum premiums. Factors that may be used to classify risks include driving history, age, sex, marital status, credit history, miles driven, type (make, model and year) of vehicle driven and number of vehicles insured. An insurer, rating organization or advisory organization may modify rates for each rating classification using sound actuarial principles to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon an insurer, rating organization or advisory organization's actual losses or expenses.

(g) **Variable Cost Loading.** In computing individual territorial base rates, an insurer, rating organization or advisory organization shall allocate as variable expenses the items provided in, and in accordance with, subparagraph (B)(i) of

subdivision (2) of subsection (b) of section 38a-686 of the Connecticut General Statutes.

(h) **Flat Dollar Cost Loading.** In computing individual territorial base rates, an insurer, rating organization or advisory organization shall allocate as fixed expenses the items provided in, and in accordance with, subparagraphs (B)(ii) and (B)(iii) of subdivision (2) of subsection (b) of section 38a-686 of the Connecticut General Statutes.

(i) **Filing Updates.** An insurer, rating organization or advisory organization shall file with the Department updated territorial indications and relativities for each of its private passenger nonfleet automobile territorial rating plans at least once every three years following its initial or amended rate filing submitted on or after July 1, 2012.

(Effective January 30, 2012)

Sec. 38a-686-3. Private passenger nonfleet automobile rate filing submission requirements

(a) **Supporting Information.** An insurer, rating organization or advisory organization shall make a private passenger nonfleet automobile rate filing with the Department each time it seeks to change the base rate on a new or renewal private passenger nonfleet automobile insurance policy. An insurer, rating organization or advisory organization shall include the information set forth in this section to actuarially support the rate being requested in its private passenger nonfleet automobile rate filing.

(b) **Actuarial Exhibits.** An insurer, rating organization or advisory organization shall file the following exhibits to support each territorial rate filing made to the Department:

(1) An exhibit showing the indicated statewide rate level change and the adopted statewide rate level change as a percentage of current rates for each rating program, identified by type of insurance coverage. The exhibit shall set forth all changes to the: (A) variable expense rate; (B) flattened expense fee; and (C) total rate.

(2) An exhibit showing the adopted rate level change for each territory by type of insurance coverage as a percentage of current rates. The exhibit shall combine the effect on rates of the variable rate portion and the flattened expense fee portion.

(3) A set of exhibits showing the insurer, rating organization or advisory organization's indicated statewide rate level changes categorized by accident year and coverage. An insurer, rating organization or advisory organization may adapt the exhibits required under this subdivision to a format that reflects the insurer, rating organization or advisory organization's specific rate review process, provided such insurer, rating organization or advisory organization shall include all actuarially supported adjustments to the insurer, rating organization or advisory organization's loss experience in such exhibits.

(4) A set of exhibits showing that the insurer, rating organization or advisory organization's base rates include, as flat dollar amounts for all territories, at least ninety per cent of its general and other acquisition expenses and one hundred per cent of its miscellaneous licenses, taxes and fees.

(5) A set of exhibits showing that the insurer, rating organization or advisory organization's individual territorial loss costs data has been moderated with reference to statewide average loss costs as specified in subdivision (4) of subsection (b) of section 38a-686 of the Connecticut General Statutes.

(6) An exhibit showing, by type of coverage, the insurer, rating organization or advisory organization's variable expense portion of premium and the flattened

expense portion of premium. The insurer, rating organization or advisory organization shall include the calculation of the flattened expense fee by type of coverage.

(7) An exhibit showing the insurer, rating organization or advisory organization's investment income as a factor of the rates, including the manner in which investment income is calculated and an explanation of how it is applied in the insurer, rating organization or advisory organization's rate filing methodology.

(8) An exhibit showing, by type of coverage, the insurer, rating organization or advisory organization's annual trend factors used in its ratemaking methodology, displaying frequency and severity separately and the combined effect of these factors on each year of experience used in the filing.

(9) An exhibit identifying the insurer, rating organization or advisory organization's name of the program and year used for the filing and showing examples of four sets of car year exposures by territory, on an earned car year basis for the most recent one-year period, for the following types of coverage: (A) bodily injury, uninsured motorist coverage and underinsured motorist coverage; and property damage liability coverages; (B) medical expense coverage; (C) comprehensive coverage; and (D) collision coverage.

(10) An exhibit showing the insurer, rating organization or advisory organization's rate order of calculation for premium determination.

(Effective January 30, 2012)

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Private Passenger Automobile Insurance Statistical Data Monitoring System

Sec. 38a-693-1. Purpose

The purpose of the regulations is to establish a Statistical Data Monitoring System (SDMS) to provide procedures to insure accuracy and reliability of private passenger automobile insurance statistical data. Such procedures will be set forth in a set of manuals referred to as the Statistical Data Monitoring System (SDMS).

(Effective September 25, 1992)

Sec. 38a-693-2. Description

(a) The SDMS will be comprised of six elements:

- (1) Systems Descriptions and Procedural Control Checklists.
- (2) Statistical Sampling Procedures (Detail Data Verification).
- (3) Reasonability Test Procedures (Detail Data Verification).
- (4) Reconciliation of Statistical Data to Financial Statement.
- (5) Annual Self-Review and Certification by the insurer or statistical agent.
- (6) Periodic Review by the Insurance Department.

(b) The SDMS utilizes a self-monitoring approach. Each company and statistical agent is required to carry out its own monitoring activities with due diligence.

(c) Certain of the SDMS elements involve similar costs, regardless of the size of the company adopting them. The SDMS manuals will specify compliance criteria which will reduce the requirements, for small companies and small systems in large companies, where the data do not have a significant impact on the aggregate statistical reporting.

(Effective September 25, 1992)

Sec. 38a-693-3. Applicability

Sections 38a-693-1 through Section 38a-693-6 shall be applicable to:

- (a) all insurers writing private passenger automobile insurance in this State; and
- (b) all statistical agents reporting private passenger automobile statistics to the Insurance Department.

(Effective September 25, 1992)

Sec. 38a-693-4. Standards

Except to the extent that it may be modified by state statutes, each insurer and statistical agent shall be guided by the Statistical Data Monitoring System promulgated by the Insurance Department of the State of New York as amended from time to time.

(Effective September 25, 1992)

Sec. 38a-693-5. Implementation

(a) Each insurer and statistical agent shall monitor private passenger automobile statistical data in accordance with the provisions of the SDMS as required by the Insurance Department.

However, the Insurance Commissioner may waive or modify any SDMS requirement(s) for an individual insurer or statistical agent where the insurer has demonstrated that the implementation of the requirement(s) would be impractical or unreasonable because of the small volume of private passenger automobile insurance premiums written by the insurer or in such other instances where the Insurance Commissioner deems that such implementation would place an unreasonable burden on the insurer or statistical agent.

(b) The statistical agents shall provide a copy of the SDMS manuals to each of their members upon request.

(c) The Insurance Commissioner shall maintain copies of the SDMS for public perusal at the Connecticut Insurance Department, 165 Capitol Avenue, Hartford, CT 06106.

(Effective September 25, 1992)

Sec. 38a-693-6. Effective dates

(a) The system to implement the Reconciliation of Statistical Data to Financial Statements is required to begin in January, 1985. The first reconciliation will cover the statistical and financial data of 1985.

(b) Reasonability Testing is required to begin with the comparison of the statistics of 1985 with the statistics of 1986.

(c) Systems Descriptions and Procedural Control Checklists are required to be completed by December 31, 1985.

(d) Statistical Sampling Procedures are required to begin by January 1, 1986. However, operational testing of the sampling procedure must begin by October 1, 1985. Although no error reports will be required from the test period, a certification that the procedures have been tested and are operational will be required.

(e) Annual Self-Review and Certification are effective consistent with the other effective dates specified herein.

(f) Periodic Review by the Insurance Department is effective upon the promulgation of these regulations. In lieu thereof, the Insurance Commissioner may accept the report of such periodic review made by the insurance supervisory official of another state if such report includes or is accompanied by a statement that the monitoring activities (of the insurer or statistical agent) are in accordance with SDMS manuals as provided for in section 38a-693-4.

(Effective September 25, 1992)

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Service Fees to Be Charged by Insurance Producers and Surplus Lines Brokers

Sec. 38a-707-1. Service fees

Properly licensed insurance agents and brokers organizing business in this state may charge service fees to their clients in accordance with the schedules shown in sections 38a-707-2 to 38a-707-8, inclusive. In addition to the scheduled fees a producer or surplus lines broker may charge as reimbursement any moneys expended by him for any (1) inspection report fees, (2) motor vehicle department reports, (3) policy reports, (4) credit card service fees, (5) regulatory fees from other jurisdictions, such as licensing fees, necessary for the placement of Connecticut risks with out-of-state exposure, (6) costs for overnight mail, or (7) telegrams or telephone calls necessary for the placement of the risk under consideration.

(Effective September 25, 1992; amended December 22, 2003)

Sec. 38a-707-2. Automobile

In accordance with subdivision (4) of subsection (a) of section 38a-329 of the General Statutes, Automobile Assigned Risk (initial policy only) \$35.00; Automobile, other than automobile Assigned Risk, all forms, nonstandard \$35.00.

(Effective September 25, 1992; amended December 22, 2003)

Sec. 38a-707-3. Owners, landlords and tenants—Manufacturers and contractors

Non-standard Owners, Landlords and Tenants and non-standard manufacturers and contractor forms may be assessed a fee of up to five percent of premium, not to exceed \$150.00.

(Effective September 25, 1992; amended December 22, 2003)

Sec. 38a-707-4. Workers' compensation assigned risk

Workers' Compensation Assigned Risk policyholders may be charged one per cent of the premium subject to a ten-dollar minimum fee and a maximum fee of two hundred and fifty dollars.

(Effective September 25, 1992; amended December 22, 2003)

Sec. 38a-707-5. Fire and allied lines

There will be no fee permitted for "Fair Plan" submissions. Non-standard fire and allied lines policyholders may be charged a fee of one per cent of the premium.

(Effective September 25, 1992; amended December 22, 2003)

Sec. 38a-707-6. Substandard errors and omissions

Substandard Errors and Omissions policyholders may be charged ten dollars or five per cent of the premiums up to a maximum of two hundred and fifty dollars.

(Effective September 25, 1992; amended December 22, 2003)

Sec. 38a-707-7. Surplus lines submissions

(a) A duly licensed producer and surplus lines broker involved in the same transaction may each charge a flat fee per policy for business placed in the surplus lines market, provided that the sum of the fee charged by such Producer and the fee charged by such surplus lines broker shall not exceed \$250.00 in the aggregate. In the alternative, such producer and surplus lines broker may charge a fee of up to five percent of the applicable premium, not to exceed \$500.00 in the aggregate.

(b) The fees referenced in this section may be charged for new and renewal business.

(Effective September 25, 1992; amended December 22, 2003)

Sec. 38a-707-8. Miscellaneous and renewals

(a) Any other service charges not scheduled in sections 38a-707-2 to 38a-707-7, inclusive, shall be submitted individually for approval. Except as provided in this section and in section 38a-707-7 of the regulations of Connecticut State Agencies, service fees shall not be permitted for renewals handled in the usual and customary manner, except that such fees may be charged on renewal business where a re-underwriting of the risk is necessary.

(b) Where, pursuant to section 38a-707-1 to 38a-707-9, inclusive, of the Regulations of Connecticut State Agencies, the same insurance policy may be assessed a service fee by both an insurance producer and a surplus lines broker, the total of such fees shall not exceed five percent of the applicable premium or \$500.00, whichever is less.

(Effective September 25, 1992; amended December 22, 2003)

Sec. 38a-707-9. Service fee disclosure

No insurance producer or surplus lines broker shall charge any service fee as specified in sections 38a-707-2 to 38a-707-8, inclusive, without first obtaining a written memorandum, signed by the party to be charged, and specifying and clearly defining the premium applicable to the policy and the amount or extent of any service fees assessed pursuant to section 38a-707-1 to 38a-707-9, inclusive, of the Regulations of Connecticut State Agencies. Such memorandum shall be kept by the producer or surplus lines broker in such manner as to be easily subject to audit or inspection by the insurance commissioner or the Commissioner's agents.

(Effective September 25, 1992; amended December 22, 2003)

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Surplus Lines Insurers

Sec. 38a-740-1. Definitions

As used in Sections 38a-740-1 to 38a-740-11, inclusive:

(a) An “affiliate” of, or person “affiliated” with, a specific person means a person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the specific person.

(b) “Alien insurance company” or “alien insurer” includes any insurance company which has been chartered by or organized or constituted within or under the laws of any state or country outside the United States.

(c) “Commissioner” means the Insurance Commissioner of this state.

(d) “Control,” “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 nonmanagement services, or otherwise, unless the power is the result of an official position with 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, ten percent or more of the voting securities of any other person.

(e) “Eligible surplus lines insurer” means an unauthorized insurer with which an excess line broker may place surplus lines insurance pursuant to Section 38a-740-2.

(f) “Surplus lines broker” means a person, firm or corporation licensed pursuant to Section 38a-794 of the General Statutes to place insurance of risks resident, located or to be performed in this state with unauthorized insurers eligible to accept such insurance.

(g) “Insurance company” or “insurer” includes any corporation, association, partnership, an insurance exchange duly authorized under the laws of any state, or combination of persons doing any kind or form of insurance business.

(h) “Person” means an individual, a corporation, a partnership, an association, a joint stock company, a business trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert.

(i) “Surplus lines insurance” means any insurance in this state of risks resident, located or to be performed in this state, permitted to be placed through an surplus lines broker with an unauthorized insurer eligible to accept such insurance.

(j) “Unauthorized insurer” means an insurer not licensed to do an insurance business in this state.

(k) “White list” means a listing by the Commissioner of the “eligible surplus lines insurers.”

(Effective September 25, 1992; transferred and amended January 16, 1996)

Sec. 38a-740-2. Eligible surplus lines insurers

No surplus lines broker may procure insurance for any subjects or risks resident, located or to be performed in this state except one which is declared to be an eligible surplus lines insurer in accordance with Section 38a-740-4.

(Effective September 25, 1992; transferred and amended January 16, 1996)

Sec. 38a-740-3. Waiver

Except when precluded by law, the Commissioner may, where good cause appears, waive the applicability of any Section of this Regulation or portion thereof, as to an insurance company whose name appears on the White List immediately prior to

the effective date of this Regulation, or an insurance company which is an affiliate of an insurer licensed in this state.

(Effective September 25, 1992; transferred and amended January 16, 1996)

Sec. 38a-740-4. Standards for eligible surplus lines insurers

No unauthorized insurer shall be or become an eligible surplus lines insurer unless declared eligible by the Commissioner in accordance with the following conditions:

(a) For each line of insurance it proposes to write as an eligible surplus lines insurer, the insurer shall:

(1) be currently licensed in the State of its domicile if chartered, incorporated, organized or constituted within the United States;

(2) be currently licensed in its United States domiciliary jurisdiction if as an alien insurer, it does business through a United States branch; or

(3) be currently licensed in its domiciliary jurisdiction outside the United States if an alien insurer.

(4) show that it writes the lines of business that it proposes to write in this State in sufficient volume as to demonstrate an expertness in insuring such product lines.

(b) Each insurer must have capital and surplus to policyholders of at least fifteen million dollars, provided those insurers presently on the list of eligible surplus lines insurers that do not meet this requirement shall have until December 31, 1997 to meet this requirement if such insurers have capital and surplus to policyholders of at least ten million dollars by December 31, 1995 and capital and surplus to policyholders of at least twelve million dollars by December 31, 1996.

(c) A determination of financial condition will be made regarding those insurers which apply. In making this determination there shall be deducted from unassigned funds any non-qualifying assets or understatement in reserves or special deposits not held on account for all policyholders. The difference between market value and amortized value of investments in bonds may be taken into consideration and also the ratio of earned premiums to surplus as regards policyholders when that ratio exceeds 3:1, as well as any other ratios that are generally acceptable among regulators and the insurance industry.

(d) The Insurance Commissioner, upon assessment of the rate of growth of the insurer, its business persistency, supporting surplus resources, business acquisition costs, claims experience and investment policies shall make a determination concerning the adequacy of equity resources as related to the insurer's business expansion. Such determination together with a review of the insurer's plan of operations both nationally and for the State of Connecticut, will be used to evaluate the insurer's potential to perform on policy obligations contracted within this State and its expertness in the business of insurance. The condition or methods of operation of the insurer must not be such as would render its operation hazardous to the public or its policyholders in this State.

(e) In order to be declared an eligible surplus lines insurer an insurance company must file an application on the form prescribed by the Insurance Commissioner and do the following:

(1) If an alien insurer, give the name and address of its United States Manager or representative.

(2) File a certificate of compliance from the public official having supervision of insurance in the company's domiciliary jurisdiction showing that it is authorized to transact the kind or kinds of insurance proposed to be transacted in Connecticut.

(3) File a legible copy of the corporate charter or articles of incorporation with all amendments thereto certified by the public officer with whom the originals are on file in its domiciliary jurisdiction.

(4) File a copy of the bylaws, as amended, certified to by the company's secretary or other officer having custody thereof.

(5) File evidence of all deposits in the United States.

(6) File a certified copy of the deed of trust filed with the jurisdiction of entry to the United States, if a branch of an alien insurer.

(7) File a statement of trusteed surplus in the United States, if an alien insurer.

(8) File a certified copy of a report of examination conducted by the company's domiciliary jurisdiction with an "as of date" no more than two years preceding its application, or such other evidence of verification of financial security as is acceptable to both its domiciliary jurisdiction and to the Commissioner.

(9) File annual statements for the two years preceding the current year for the type(s) of insurance proposed to be transacted in this state. They shall be in such form and with such detail as is prescribed by the Commissioner.

(10) File a copy of any agreements by which the right to conduct or influence any of the affairs of the company is transferred to others, also any employment or deferred compensation agreements in which any officer, director or shareholder who controls five percent or more of the outstanding shares of the company directly or indirectly participates.

(11) File audit reports for two complete fiscal years immediately preceding the date of application certified by the company's outside public accounting firm (if the applicant has appointed independent outside accountants). If not contained in the report, a reconciliation, prepared by the independent accountant, shall be furnished which details adjustments from original basis of presentation to statutory form. Include any comments or management letters prepared by the outside accountant, as well as recommendations relative to adequacy of internal controls or a signed statement by the independent accountant that no recommendations have been rendered to management.

In the case of an insurance exchange created under the laws of any state and where the exchange requires its syndicates to file audited financial statements on an annual basis, the exchange must provide the Commissioner with a certification from the Insurance Department of its state of domicile that such statements have been filed by each syndicate and are available for the Commissioner's inspection upon request. The certification must include a schedule of capital and surplus for each syndicate so filing.

(12) File a detailed narrative of the company's plan of operations for this state and nationally.

(13) File a statement of ownership of the applicant. Include all shareholders of record who control five percent or more of the outstanding shares of the applicant directly or indirectly.

(14) File biographical data respecting all directors and the following officers of the applicant: The president, vice president, secretary, treasurer, chief actuary, general counsel, comptroller and any person, however described, who enjoys, in fact, the executive authority of any such officers, including a statement that no officer, director or five percent shareholder has been convicted of a felony; or if such persons have been so convicted, a description of the nature of the crime and the address of the court and docket number of the case when judgment was entered.

(15) File copies of all annual, quarterly or other reports, and proxy statements made by the applicant and its parent to stockholders and policyholders during the preceding twelve month period.

(16) File any prospectus of the company or its parent within the preceding three years.

(17) File a copy of the most recent Form 10-K, if the applicant or any of its affiliates are regulated by the Securities and Exchange Commission.

(18) File a copy of the holding company registration statement, and any amendments thereto, as filed with the insurance supervisory official in the jurisdiction where the company is registered for the current year.

(19) If a license has been refused or approval as an eligible surplus lines insurer has been refused or withdrawn by any jurisdiction, furnish an explanation and a copy of any refusal or withdrawal. Also include any disciplinary action by any jurisdiction in the most recent two year period.

(f) If an alien insurer as defined in Section 38a-740-1 (b) of this regulation, or group of insurers located outside the United States, such insurer or insurers shall establish and maintain a United States trust fund in the following amounts: (1) In the case of a Lloyd's plan or other similar group of insurers, which consists of unincorporated individual insurers, or a combination of both unincorporated and incorporated insurers, such trust shall be in the amount of one hundred million dollars which shall be held jointly for the benefit of any United States surplus lines policyholder of any member of the group.

(1) The incorporated members of the group shall not be engaged in any other 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.

(2) In the case of a group of incorporated insurers under common administration, which has continuously transacted an insurance business outside the United States for at least three years immediately prior to the effective date of this regulation, and which submits to this state's authority to examine its books and records and agrees to bear the expense of the examination:

(A) The group shall maintain an aggregate policyholders' surplus of ten billion dollars; and

(B) The group shall maintain in trust a surplus in the amount of one hundred million dollars which shall be available for the benefit of United States surplus lines policyholders of any member of the group; and

(C) Each insurer which is a member of the group shall individually maintain capital and surplus of not less than twenty-five million dollars per company.

(3) In the case of all other alien insurers, such insurer shall establish and maintain in the United States a trust fund for the benefit of the United States surplus lines policyholders of such insurer, in the minimum amount of five million four hundred thousand dollars, except that those insurers on the list of eligible surplus lines insurers on the effective date of this regulation that do not meet this requirement shall have until December 31, 1996 to meet this requirement if such insurers have a United States trust fund in the minimum amount of two million five hundred thousand dollars as of the effective date of this regulation and a United States trust fund in the minimum amount of three million five hundred thousand dollars as of December 31, 1995.

(4) The trust funds required by this subsection shall be maintained in an irrevocable trust account in the United States in a qualified financial institution and shall consist of cash, securities, letters of credit or investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state and, in addition, shall substantially satisfy the requirements of the Standard Form Trust Agreement required for listing with the NAIC International Insurers Department.

(5) Insurers in compliance with subsections (1) or (2) of this section shall not be subject to section 38a-740-4 (b) of this regulation.

(6) In the case of an insurance exchange created by the laws of a state other than this state:

(A) The syndicates of the exchange shall maintain under terms acceptable to the Commissioner capital and surplus, or its equivalent under the laws of its domiciliary jurisdiction, of not less than seventy-five million dollars in the aggregate; and

(B) The exchange shall maintain under terms acceptable to the Commissioner not less than fifty percent of the policyholder surplus of each syndicate in a custodial account accessible to the exchange or its domiciliary Commissioner in the event of insolvency or impairment of the individual syndicate; and

(C) In addition, each individual syndicate to be eligible to accept surplus lines insurance placements from this state shall meet either of the following requirements:

(i) For insurance exchanges which maintain funds in an amount of not less than fifteen million dollars for the protection of all exchange policyholders, the syndicate shall maintain under terms acceptable to the Commissioner minimum capital and surplus, or its equivalent under the laws of the domiciliary jurisdiction, of not less than five million dollars; or

(ii) For insurance exchanges which do not maintain funds in an amount of not less than fifteen million dollars for the protection of all exchange policyholders, the syndicate shall maintain under terms acceptable to the commissioner minimum capital and surplus, or its equivalent under the laws of its domiciliary jurisdiction, of not less than the minimum capital and surplus requirements under the laws of its domiciliary jurisdiction or fifteen million dollars, whichever is greater.

(g) The insurer must be of good reputation as to the providing of service to its policyholders and the payment of losses and claims. The insurer shall designate in writing to the Commissioner the name of the proper individual in its employ who is directly and actively in charge of and responsible for handling any and all insurance claims and to whom all correspondence regarding such claims may be directed. Any personnel changes affecting such previously designated individual shall be reported to the Department and indicate the present designated individual responsible for and in charge of handling of such insurance claims.

(h) No insurer shall be an eligible surplus lines insurer the management of which is found by the Commissioner to be incompetent or untrustworthy, or lacking in insurance company managerial experience as to make the proposed operation hazardous to the insurance-buying public; or which the commissioner has good reason to believe is affiliated with any person or persons whose business operations are or have been detrimental to policyholders, stockholders, investors, creditors or to the public.

(i) No insurer shall be declared an eligible surplus lines insurer unless it has first appointed in writing the Insurance Commissioner of this State and his successors in office to be its attorney in this State, upon whom all lawful process, in any action or proceeding against it, may be served with the same effect as if the company was a domestic corporation. Such power of attorney shall be of the same legal force and validity as if served on the company, and that the authority shall continue in force so long as any certificate of membership, policy or liability remains outstanding against the company in this State. A certificate of such appointment, certified and authenticated, shall be filed in the office of the Commissioner and copies certified by him shall be sufficient evidence. Service upon such attorney shall be sufficient service upon the principal.

(j) No insurer shall be declared an eligible surplus lines insurer that is owned or financially controlled by another state or territory of the United States or an alien nation or any state or province thereof.

(k) In addition to all of the other requirements of this subsection, an insurer not domiciled in the United States or its territories shall be listed by the NAIC International Insurers Department. The commissioner may waive the requirements of this subsection upon an affirmative finding of acceptability by the commissioner if the commissioner is satisfied that the placement of insurance with the insurer is necessary and will not be detrimental to the public and the policyholder. In determining whether business may be placed with the insurer, the commissioner may consider such factors as:

- (i) The interests of the public and policyholders;
- (ii) The length of time the insurer has been authorized in its domiciliary jurisdiction and elsewhere;
- (iii) Unavailability of particular coverages from authorized insurers or unauthorized insurers meeting the requirements of this subsection;
- (iv) The size of the company as measured by its assets, capital and surplus, reserves, premium writings, insurance in force or other appropriate criteria;
- (v) The kinds of business the company writes, its net exposure and the extent to which the company's business is diversified among several lines of insurance and geographic locations; and
- (vi) The past and projected trend in the size of the company's capital and surplus considering such factors as premium growth, operating history, loss and expense ratios, or other appropriate criteria.

(L) The surplus lines insurer shall provide to the commissioner a copy of its current annual statement certified by the insurer and an actuarial opinion as to the adequacy of, and methodology used to determine, the insurer's loss reserves. The statement shall be provided at the same time it is provided to the insurer's domicile, but in no event more than eight months after the close of the period reported upon, and shall be certified as a true and correct copy by an accounting or auditing firm licensed in the jurisdiction of the insurer's domicile and certified by a senior officer of the nonadmitted insurer as a true and correct copy of the statement filed with the regulatory authority in the domicile of the nonadmitted insurer. In the case of an insurance exchange qualifying under subdivision (6) of subsection (f) of this section, the statement may be an aggregate combined statement of all underwriting syndicates operating during the period reported.

(Effective September 25, 1992; transferred and amended January 16, 1996)

Sec. 38a-740-5. Hearing

Any insurer whose application to be declared an eligible surplus lines insurer is denied may request the Commissioner for a hearing.

(Effective September 25, 1992; transferred and amended January 16, 1996)

Sec. 38a-740-6. Requirements of eligible surplus lines insurers

In order to remain an eligible surplus lines insurer in Connecticut the unauthorized insurer shall comply with the following requirements.

(a) The insurer shall continue to maintain the same financial stability and condition, qualifications and general suitability necessary to be declared an eligible surplus lines insurer pursuant to Section 38a-740-4 of the Regulations of Connecticut State Agencies.

(b) (1) Each foreign insurer shall, annually, on or before the first day of March, submit to the Commissioner, by electronically filing with the National Association of Insurance Commissioners, a true and complete report, signed and sworn to by its president or a vice president, and secretary or an assistant secretary, of its financial condition on the thirty-first day of December next preceding, in such form and with such detail as is prescribed by the Commissioner. An electronically filed report that is timely submitted to the National Association of Insurance Commissioners is deemed to have been submitted to the Commissioner in accordance with this subdivision.

(2) Each alien insurer shall file annually, on or before the fifteenth day of May, a true and complete report, signed and sworn to by its president or a vice president, and secretary or an assistant secretary, of its financial condition on the thirty-first day of December next preceding, in such form and with such detail as is prescribed by the Commissioner.

(3) The Commissioner may grant extensions of time in which to file such reports when an insurer can demonstrate to the satisfaction of the Commissioner the need for such an extension. In addition to such annual report, the Commissioner, when he deems it necessary, may require any eligible surplus lines insurer to file financial statements on a quarterly basis. Further, whenever the Commissioner has determined that more frequent reports are required because of certain factors or trends affecting companies writing a particular class or classes of business or because of changes in the company's management or financial or operating condition, he may require any eligible surplus lines insurer to file financial statements on other than an annual or quarterly basis.

(4) Notwithstanding the provisions of this Subsection to the contrary, when the syndicates of an insurance exchange are required to file annual reports with the exchange on the National Association of Insurance Commissioners Convention Form Annual Statement, an insurance exchange created under the laws of any state shall file such report on the first day of May, however, such report may be filed on a combined basis.

(c) The insurer shall file at least once in every five years an official report of an examination made by governmental authorities of the domiciliary jurisdiction of the insurer. The examination report shall be concerned with the condition and affairs of the company. In place of such an official report, the insurer may file such other evidence of verification of financial security as is acceptable to both its domiciliary jurisdiction and to the Commissioner.

(d) The insurer shall file any other information requested by the Commissioner concerning material changes in its financial condition, operations or management.

(e) The insurer shall remit to the Commissioner the fees required by Section 38a-740-11 of the Regulations of Connecticut State Agencies.

(f) If it appears to the Commissioner upon satisfactory evidence, that the surplus to policyholders of an eligible surplus lines insurer as appears on its financial statement is reduced forty percent below the minimum requirement for eligibility, such company shall not issue any new policies or transact any new business until it receives from the Commissioner authority to do so or until authorized by court order in an action brought for that purpose.

(g) If the deficiency is more than twenty and less than forty percent of the required surplus and the directors of the company certify under oath that the deficiency will be restored by the company such company may continue business for thirty days from the date such deficiency is found by the Commissioner. If at the expiration of the thirty days, or any extension thereof granted by the Commissioner in writing,

any portion of the deficiency is not restored, the company shall not thereafter issue new policies or transact new business until authorized by the Commissioner or authorized by court order in an action brought for that purpose.

(Effective September 25, 1992; transferred and amended January 16, 1996; amended March 5, 2009)

Sec. 38a-740-7. Notification

Any eligible surplus lines insurer is required to notify the Insurance Commissioner within thirty (30) days of the happening of any one or more of the following:

(1) the suspension or revocation of a license or right to transact business in another jurisdiction;

(2) the receipt of an order or complaint to show cause why the license or right to transact business should not be suspended or revoked, or charges of any type filed by a state, federal agency or any other jurisdiction which, if substantiated, could result in suspension or revocation of a license, certificate of authority, or right to transact business in another jurisdiction;

(3) the imposition of a penalty by any other state, federal agency or any other jurisdiction for any violation of the insurance or insurance related laws of such other state, federal agency or jurisdiction; or

(4) any change in control of the company.

(Effective September 25, 1992; transferred and amended January 16, 1996)

Sec. 38a-740-8. List of eligible surplus lines insurers

The Commissioner shall from time to time publish a list of all authorized insurers declared to be eligible surplus lines insurers, and shall mail a copy thereof to each licensed surplus lines broker at his office last of record with the Commissioner.

(Effective September 25, 1992; transferred and amended January 16, 1996)

Sec. 38a-740-9. Withdrawal of eligibility; grounds; notice

If at any time the Commissioner has reason to believe that any unauthorized insurer having been declared an eligible surplus lines insurer pursuant to Section 38a-740-4, is impaired financially or no longer meets the requirements for eligibility as set forth in Section 38a-740-6, he shall declare such insurer no longer an eligible surplus lines insurer. If the Commissioner determines, after a hearing thereon of which reasonable notice was given to all licensed surplus lines brokers that an insurer currently eligible as a surplus lines insurer has violated the laws of Connecticut, or has failed to make reasonably prompt settlement of just claims for losses and/or return premiums he may declare such insurer no longer an eligible surplus lines insurer. The Commissioner shall promptly mail notice of all such declarations to each surplus lines broker at his address last of record with the Commissioner.

(Effective September 25, 1992; transferred and amended January 16, 1996)

Sec. 38a-740-10. Actual financial condition and claim practices of eligible surplus lines insurers

Nothing in Sections 38a-740-1 to 38a-740-9, inclusive, shall be deemed to impose on the Commissioner any duty or responsibility to determine the actual financial condition or claims practices of any unauthorized insurer; and the status of being an eligible surplus lines insurer, if granted by the Commissioner, shall be construed to mean only that the insurer appears to be sound financially and to have satisfactory claims practices, and that the Commissioner has no credible evidence to the contrary.

(Effective September 25, 1992; transferred and amended January 16, 1996)

Sec. 38a-740-11. Fees

(a) Upon the initial filing of the material required by Section 38a-740-4, the unauthorized insurer shall pay to the Commissioner a nonrefundable fee of one thousand dollars by check or money order made payable to the Treasurer, State of Connecticut.

(b) On or before the first day of May of each year after the initial filing of the material required by Section 38a-740-4, each unauthorized insurer declared to be an eligible surplus lines insurer pursuant to Section 38a-740-4 and remaining on the list of eligible surplus lines insurers published pursuant to Section 38a-740-8, shall pay to the Commissioner an annual fee of sixty three dollars by check or money order made payable to the Treasurer, State of Connecticut.

(Effective September 25, 1992; transferred and amended January 16, 1996)

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Transferred 38a-769-1—38a-769-8

Public Adjusters

Secs. 38a-769-1—38a-769-8.

Transferred, June 22, 1995.

<u>Former Section</u>	<u>New Section</u>
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38a-769-2	38a-788-2
38a-769-3	38a-788-3
38a-769-4	38a-788-4
38a-769-5	38a-788-5
38a-769-6	38a-788-6
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Continuing Education of Insurance Producers

Sec. 38a-782a-1. Definitions

As used in sections 38a-782a-1 to 38a-782a-17, inclusive, of the Regulations of Connecticut State Agencies:

(1) “Audit” means: (A) department or designee activity to monitor the offering of courses or examinations, including visits to classrooms, test sites, and administrative offices where documentation of individual attendance and completion records, and documentation of instructor qualifications pursuant to section 38a-782a-6 are maintained; and (B) re-evaluating approved classroom course and seminar outlines, and self-study programs based on current guidelines;

(2) “Biennium” means, with respect to each individual producer, the two-year period ending on the expiration date of the producer’s insurance license;

(3) “Class” means a course designed to be presented live to a group of producers using lecture, video, satellite, or other audio-visual presentation material which has an approved instructor or monitor present in the classroom during the presentation;

(4) “Commissioner” means the Insurance Commissioner of the State of Connecticut;

(5) “Completion” means: (A) the attainment by individuals enrolled in a self study course of a passing grade of seventy percent or better on an examination monitored by an impartial and disinterested person; or (B) Class attendance of at least eighty percent of sessions approved for the course; or (C) Seminar attendance for the full time assigned for each workshop or break-out session selected;

(6) “Course” means a program of instruction approved by the commissioner for a specific number of continuing education credit hours;

(7) “Credit hour” means a value assigned to a course approved by the commissioner that is equivalent to fifty minutes of classroom instruction;

(8) “Department” means the Insurance Department of the State of Connecticut;

(9) “Evaluation and assessment methods” means a methodology to determine the proficiency attained by a producer in the subject matter of a course upon completion of such course;

(10) “Line of authority” means: (A) property and casualty, which includes property, casualty, property and casualty, bail bonds, surety and surplus lines; and (B) life and health, which includes life, health, life and health, fixed annuities, variable life and variable annuities;

(11) “Person” means an individual, a corporation, a partnership, an association, or other legal entity;

(12) “Self-study course” means a course: (A) that does not require a student to attend an organized class or seminar; (B) that includes an examination adequately covering course materials set forth in the course outline; and (C) for which credits will be granted only upon achieving a score of seventy percent or better on the examination;

(13) “Seminar” means a course designed to be presented using lecture, video, satellite, or other audio-visual presentation material by an individual or individuals with special expertise and which has an approved speaker or instructor present in the classroom during the presentation; and

(14) “Sponsor” means any person approved or seeking approval to offer a continuing education course and charged with approving instructors for such course.

(Adopted effective February 1, 1998; amended February 1, 2000, September 17, 2002, November 2, 2006)

Sec. 38a-782a-2. Requirements for licensees

(a) Every resident and nonresident producer shall furnish evidence to the commissioner in a manner prescribed by the commissioner that the continuing education requirements of this regulation have been satisfied.

(b) Except as provided by section 38a-782a-13 of the Regulations of Connecticut State Agencies, all producers shall complete a minimum of twenty-four hours of continuing education credits each biennium, of which a minimum of three credit hours of Connecticut insurance law and regulations, or ethics are required. Of the total, a minimum of six credit hours are required for each line of authority held by the producer on the first day of each biennium. Instructors of approved continuing education courses shall earn the same number of credit hours for instructing as the students receive for successfully completing the course.

(Adopted effective February 1, 1998; amended February 1, 2000, September 17, 2002)

Sec. 38a-782a-3. Administration of continuing education

(a) The commissioner may contract with a competent person to (1) review sponsor qualifications, course content and credit hours assignment for continuing education courses; (2) record successful completion of the course by producers; and (3) perform other pertinent services deemed appropriate by the commissioner. The commissioner shall approve sponsor registration, courses and assignment of credit hours to approved courses. If the commissioner contracts with a competent person or corporation for the administration of the continuing education program, that person or corporation may charge the participating sponsors and producers reasonable fees, subject to the approval of the Insurance Department, for services rendered.

(Adopted effective February 1, 1998; amended February 1, 2000)

Sec. 38a-782a-4. Sponsor responsibilities

(a) Each sponsor of a continuing education course shall submit an application to the department or its designee on a form prescribed by the commissioner, including the name and address of the applicant; an application for one or more courses; and any other information requested by the commissioner.

(b) Each sponsor is responsible for obtaining approval for its continuing education courses; verifying the qualifications of instructors; providing course schedules; monitoring classroom attendance; supervising and evaluating courses and instructors; investigating complaints regarding courses and instructors; administering examinations where applicable; and submitting, within fifteen (15) calendar days of the completion of a course, course attendance and completion rosters and other information required by the department.

(c) Sponsors shall retain course attendance and completion records for four years.

(d) Sponsors shall comply with the Americans With Disabilities Act and all applicable state and federal equal employment opportunity and safety requirements.

(e) Each sponsor shall publish and abide by a refund policy which is subject to approval by the department.

(f) Each sponsor shall provide to each student upon completion of a course a certificate showing (1) the date on which the course was completed; (2) the attendance percentage of the course achieved by the student; and, (3) the course name and number, and the sponsor's name and number.

(Adopted effective February 1, 1998; amended February 1, 2000, September 17, 2002)

Sec. 38a-782a-5. Course approval

(a) Each course shall be approved by the commissioner prior to the initial course offering, and before any advertisement of, or solicitation for, the course is effected.

It is the sponsor's responsibility to provide an acceptable application on a form approved by the commissioner for a course to be approved. The application shall include a detailed course content outline and the sponsor's tuition and fee refund policy. The department shall not be liable to the sponsor for any action taken or any expense incurred by the sponsor, such as advertising costs, in anticipation of course approval. The department will approve a course as an acceptable continuing education program if it: (1) Is a formal program of learning which contributes directly to the professional competence of a producer; (2) is not defined under this section as a "not approved" course; (3) has significant intellectual or practical content to enhance and improve the knowledge of the participants with regard to subjects of insurance; (4) includes evaluation and assessment methods; (5) is classified based on the level of ability required to benefit from the course as basic, intermediate, or advanced; (6) includes a bibliography or reference sources, if any; and (7) includes a list and sample of supplemental teaching aids, if any.

(b) The following are "not approved" courses: (1) Courses approved for pre-licensure training; (2) Courses in: (A) mechanical, office or business skills (including typing, speed reading, etc.); (B) the use of calculators, computers or other machines or equipment; (C) the use of computer software or equipment except in computer-based needs analysis or computer solutions to risk management that relate to insurance customers; or (D) accounting or tax preparation in connection with the business of the producer; (3) Courses that relate only to the organizational procedures and internal policies of an individual insurer; (4) Courses in (A) motivation; or (B) salesmanship or sales promotion, including meetings held in conjunction with the general business of the producer; (5) Courses primarily intended to impart knowledge of specific products of specific insurers, if the use of the products relates to sales promotion or marketing of one or more of the products discussed.

(c) If approval has been granted for the initial offering of a course, recertification may be granted without requiring a new application. Recertification will require only information concerning course content submitted on a form acceptable to the commissioner.

(d) Materials and course content used in subsequent offerings of approved courses shall be updated to maintain currency of the information.

(e) Classroom courses which have not been used for a period of five years shall be purged from the department's database file of approved courses. Future use of purged courses shall require a new application.

(f) The department reserves the right to audit courses and administrative records with or without notice to the sponsor. Audits shall result in notice to the sponsor of any deficiencies found and of corrective action required by the sponsor where warranted. The department may reduce the number of approved credit hours for the course, or disapprove the course entirely if the sponsor fails to correct the deficiencies.

(g) The department or its designee shall approve or disapprove a course within sixty days of receipt of application for approval. Any rejection shall be in writing and shall include the reasons for disapproval.

(Adopted effective February 1, 1998; amended February 1, 2000)

Sec. 38a-782a-6. Instructor qualifications

(a) Sponsors shall select qualified instructors for continuing education courses possessing at least two of the following qualifications: (1) A minimum of three years working experience in the subject matter being taught; (2) two teaching experiences certified by the sponsor; (3) a professional designation from a recognized

industry organization or association; (4) a degree or certificate from an accredited school in the subject matter being taught; (5) specialized knowledge in the subject matter being taught.

(b) Certification of the instructor's experience or education shall be furnished by the sponsor.

(c) If the commissioner denies approval to instruct continuing education courses to an instructor, a six month waiting period shall elapse before a sponsor may submit a new certification request for said instructor.

(d) The department shall have the right to review business or employment records of approved instructors and disapprove and remove any instructor against whom any disciplinary action was taken by this or any other state, country or territory because of activities involving such instructor's insurance license, at any time before or after being approved as instructor. Sponsors are responsible for verifying the eligibility of instructors before approval.

(e) Approved instructors teaching approved classroom courses or seminars shall display a photo I. D. to any department or department's representative's auditor who conducts an official audit during their instruction time.

(f) Instructors shall have the authority and responsibility to deny admittance to anyone who disrupts the class or is inattentive. Students excluded from a course or seminar under this subsection may be refunded their tuition, or a portion thereof, if the provider's policy so provides.

(Adopted effective February 1, 1998; amended February 1, 2000)

Sec. 38a-782a-7. Self-study courses

Self-study courses may receive continuing education approval provided they include an examination on course material approved by the commissioner and administered by an impartial and disinterested person who shall not be in the direct line of supervision of any person taking the examination, nor have any financial interest in the success of any person taking the examination.

(Adopted effective February 1, 1998; amended February 1, 2000)

Sec. 38a-782a-8. Attendance

(a) The producer shall present a picture identification to the course administrator upon admittance to the course.

(b) If six credit hours or less are assigned to a course, the producer shall attend one hundred percent of the course to receive any credit hours.

(c) If more than six credit hours are assigned to a course for which there is no examination, and the producer attends one hundred percent of the course, the producer shall receive one hundred percent of the credit hours assigned to the course.

(d) If more than six credit hours are assigned to a course for which there is no examination and the producer attends at least seventy percent of the course the producer shall receive seventy percent of the credit hours assigned to the course.

(e) If more than six credit hours are assigned to a course for which there is an examination, and the producer passes the examination for the course and attends at least seventy percent of the course, the producer shall receive one hundred percent of the credit hours assigned to the course.

(f) If more than six credit hours are assigned to a course for which there is an examination, and the producer does not pass the examination for the course but attends at least seventy percent of the course, the producer shall receive seventy percent of the credit hours assigned to the course.

(g) Credit hours per course granted under this section shall be rounded up to the nearest whole number.

(h) A producer shall not receive any additional credit for courses that the producer has previously completed, and for which credits have previously been received, in the same biennium.

(Adopted effective February 1, 1998; amended February 1, 2000, September 17, 2002)

Sec. 38a-782a-9. Advertising

(a) Courses shall not be advertised as approved for continuing education credit unless such approval has been granted by the commissioner in writing.

(b) When a course has been approved for continuing education credit and is advertised as such, the advertising shall include: (1) the sponsor name and course title; (2) the statement “Approved by the State of Connecticut Insurance Department for insurance producer continuing education credit”; (3) the number of approved credit hours; (4) the type of licensee for whom the course would be most applicable; and (5) all fees and associated expenses.

(c) Advertising shall be complete, truthful, clear, and not deceptive or misleading.

(d) The commissioner may withdraw his approval of any violator of this section to provide or conduct courses or may impose other penalties provided by law.

(Adopted effective February 1, 1998; amended February 1, 2000)

Sec. 38a-782a-10. Carryover credit

No credit hours may be carried over from one biennium to the next.

(Adopted effective February 1, 1998; amended February 1, 2000)

Sec. 38a-782a-11. Advisory board

The commissioner shall appoint an advisory board to recommend reasonable rules to the commissioner for promulgation of regulations pursuant to section 38a-782a of the Connecticut General Statutes. The commissioner may adopt, reject, or modify such recommendations. The board shall periodically make recommendations to the commissioner regarding development of criteria relating to the awarding of contracts for continuing education; offer guidance regarding approval or disapproval of courses, credit hours, qualifications of course sponsors and instructors; recommend changes to sections 38a-782a-1 through 38a-782a-17, inclusive, of the Regulations of Connecticut State Agencies; and perform other services requested by the commissioner. The board shall be comprised of twelve members from the insurance industry, and from the education and the producer community to be selected by the commissioner.

(Adopted effective February 1, 1998; amended February 1, 2000)

Sec. 38a-782a-12. Extension

Except in the case of a licensed insurance producer who is unable to comply with the continuing education requirements of sections 38a-782a-1 to 38a-782a-17, inclusive, of the Regulations of Connecticut State Agencies due to military service, a producer shall not be entitled to any extensions of time in which to complete the continuing education requirements.

(Adopted effective February 1, 1998; amended February 1, 2000, September 17, 2002, November 2, 2006)

Sec. 38a-782a-13. Exemptions

(a) Producers who seek reinstatement of their license within one year after the license expiration date shall be required to complete any deficient continuing educa-

tion credit hours for the previous biennium and successfully complete twenty four credit hours of continuing education during the current biennium.

(b) Producers who become Connecticut residents and are granted a license based on their previous home state licensure shall not be required to complete Connecticut continuing education during the initial biennium.

(c) Producers who hold a license in states requiring continuing education for their insurance producers, and who furnish evidence of their compliance with the continuing education requirements in such states are exempt from meeting this state's continuing education requirements provided that the insurance supervisory official of the state in which the producer completes the continuing education requirements will grant similar exemptions to Connecticut residents licensed therein who have satisfied Connecticut's continuing education requirements.

(d) Producers whose only line of authority is (1) credit insurance, which includes credit life, credit accident and health, and mortgage guaranty, or (2) travel accident and travel baggage insurance are exempt from the twenty-four hours of continuing education credits requirement of section 38a-782a-2 of the Regulations of Connecticut State Agencies.

(e) Producers whose licenses are renewed by the commissioner for one year according to the transitional process outlined in section 38a-784 of the Supplement to the General Statutes shall be required to complete twelve credit hours of continuing education during the transitional period.

(Adopted effective February 1, 1998; amended February 1, 2000, September 17, 2002, November 2, 2006)

Sec. 38a-782a-14. Failure to comply

(a) Failure of a producer to satisfy the requirements of this regulation by the last day of the biennium applicable to such producer by obtaining the continuing education credits required by sections 38a-782a-1 to 38a-782a-17, inclusive, of the Regulations of Connecticut State Agencies shall result in the nonrenewal of his or her insurance producer license, unless such producer has been granted an extension pursuant to section 38a-782a-12. The commissioner shall not refuse to renew the license of a producer who fails to comply with the continuing education requirements unless the commissioner has provided thirty days' written notice of such impending action to such producer. During the thirty day notice period, the producer may provide proof of compliance with the continuing education requirements of sections 38a-782a-1 to 38a-782a-17, inclusive of the Regulations of Connecticut State Agencies in a manner and form acceptable to the commissioner.

(b) No resident or nonresident producer whose license has been nonrenewed for failure to comply with the continuing education requirements shall apply for reinstatement of his or her license unless the producer has successfully completed the continuing education requirements for the period.

(c) Completion of such requirements and reinstatement of a producer's license shall not reduce the producer's continuing education requirements for the biennium next following the reinstatement.

(Adopted effective February 1, 1998; amended February 1, 2000, November 2, 2006)

Sec. 38a-782a-15. Appeals

(a) The commissioner shall provide, pursuant to section 38a-19 of the Connecticut General Statutes, a reasonable means whereby any person aggrieved by the action of the commissioner with respect to the enforcement of sections 38a-782-1 through

38a-782-17, inclusive, of the Regulations of Connecticut State Agencies may be heard, in person or by an authorized representative, to review the grievance.

(b) Any person aggrieved by an action of the commissioner after an appeal under subsection (a) of this section may appeal in accordance with the provisions of section 4-183 of the Connecticut General Statutes.

(Adopted effective February 1, 1998; amended February 1, 2000)

Sec. 38a-782a-16. Sanctions

(a) The commissioner may deny, suspend or revoke approval of a sponsor or course if the sponsor, instructor or course is not in compliance with sections 38a-782a-1 to 38a-782a-17, inclusive, of the Regulations of Connecticut State Agencies.

(b) Any of the following shall constitute cause for administrative action under section 38a-774 of the Connecticut General Statutes: (1) a determination by the commissioner that a sponsor (A) has failed to maintain continuing education course completion records for the current and preceding biennium; or (B) has failed to submit course attendance and completion rosters as provided by section 38a-782a-4(b) of the Regulations of Connecticut State Agencies; or (2) a determination by the commissioner that a producer (A) obtained or accepted any certificate of completion from a provider where the producer has not attended a course for the required time; (B) cheated or used unauthorized materials or received unauthorized assistance during an examination; or (C) violated any other provision of sections 38a-782a-1 to 38a-782a-17, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective February 1, 1998; amended February 1, 2000, September 17, 2002)

Sec. 38a-782a-17. Hearing costs

The cost for the transcript of any hearing resulting from the failure of a producer to successfully complete the continuing education requirements, or requested by a producer or sponsor aggrieved by a decision of the commissioner concerning a violation of sections 38a-782a-1 to 38a-782a-17, inclusive, of the Regulations of Connecticut State Agencies shall be borne by the producer or sponsor.

(Adopted effective February 1, 1998; amended February 1, 2000)

Sec. 38a-782a-18. Effective date

Sections 38a-782a-1 through 38a-782a-17, inclusive, of the Regulations of Connecticut State Agencies shall take effect on February 1, 1998.

(Adopted February 1, 1998)

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Public Adjusters

Sec. 38a-788-1. Authority

The following regulations are promulgated under the authority set forth in Section 38a-769 of the Connecticut General Statutes.

(Effective September 25, 1992; transferred June 22, 1995)

Sec. 38a-788-2. Definitions

(a) "Public adjuster" means any person, partnership, association or corporation who or which practices as a business the adjusting of loss or damage by fire or other hazard under any policies of insurance in behalf of the insured under such policies, or who advertises or solicits business as such adjuster, or holds himself out to the public as engaging in such adjusting as a business.

(b) "Employment Contract" refers to that contract between a public adjuster and a client mandated by Section 38a-769 of the General Statutes.

(Effective September 25, 1992; transferred June 22, 1995)

Sec. 38a-788-3. Prohibited practices

(a) No public adjuster shall pay any money or give anything of value to any person in consideration of a direct or indirect referral of a client or potential client.

(b) No public adjuster shall pay any money or give anything of value to any person as an inducement to refer business or clients.

(c) No public adjuster shall rebate to a client any part of a fee specified in any employment contract.

(d) No public adjuster shall solicit a client between the hours of 8 p.m. and 8 a.m.

(e) No public adjuster shall split his fee or pay any money to any person for services rendered to a client unless such other person is also licensed as a public adjuster.

(f) No public adjuster shall have any interest directly or indirectly in any construction firm, salvage firm, or appraisal firm. The word "firm" includes any corporation, partnership, association or individual.

(g) No public adjuster shall, in connection with the transaction of his business as a public adjuster, make any misrepresentation of facts or advise any person on any question of law.

(h) No public adjuster shall make any false statements about any insurance company or its employees, agents or representatives.

(i) No public adjuster shall solicit employment of a client in connection with any loss which is the subject of an employment contract with another public adjuster.

(j) No public adjuster shall represent both an insurer and insured simultaneously.

(k) No public adjuster shall advance any monies to a client pending the settlement of a loss where such amount would be included in a final settlement.

(Effective September 25, 1992; transferred June 22, 1995)

Sec. 38a-788-4. Disclosures

(a) A public adjuster shall disclose in writing to the client any interest the public adjuster has in loss proceeds other than those acquired by his employment contract.

(b) A public adjuster in soliciting a client for employment shall display his license and immediately inform such client that the adjuster does not represent any insurance company, or insurance company adjusting firm. The adjuster shall inform such client that his services are available for a fee to be paid by the client, and shall give

such client a card identifying the public adjuster and specifying on such card the amount of fee charged by the public adjuster.

(Effective September 25, 1992; transferred June 22, 1995)

Sec. 38a-788-5. Settlement offers

Any written offer to settle a loss received by a public adjuster shall be transmitted to the client and, if rejected by the client, such offer shall be acknowledged by an appropriate endorsement thereto.

(Effective September 25, 1992; transferred June 22, 1995)

Sec. 38a-788-6. Form of contract

No public adjuster shall enter into an employment contract except in conformity with this regulation. There shall be a true copy of the employment contract which shall be given to the client at the time the contract is signed. The contract and copy(ies) of the contract shall (1) be printed on white or cream paper in dark or black ink; (2) have section titles captioned in bold face type which otherwise stands out significantly from the text; (3) have statements on contract which read "read both sides before signing" and "I have read the information on both sides of this contract" printed in 18 point bookman type; (4) use layout and spacing which separates the paragraphs from each other and from the border of the paper; (5) be on one piece of paper measuring 8¹/₂" x 11" to be printed on both sides and which shall state:

(continued next page)

(1) On side one:

**INFORMATION ABOUT YOUR
PUBLIC ADJUSTER EMPLOYMENT CONTRACT**

YOUR LEGAL RIGHTS:

Cancellation: You may cancel this contract by notifying us at the address shown on the other side of this page, in writing, by certified mail, return receipt, postmarked not later than midnight two (2) days following the day this contract is signed. If the contract is signed on a Friday, Saturday or Sunday, you will have until midnight on the following Tuesday to mail the notice of cancellation to us as described above.

Settlement offer: We shall forward to you any written settlement offer from the insurance company.

Fee: Our services are available for a fee to be paid by you. We cannot charge you a fee greater than ten percent (10%) of the actual or final settlement of the loss covered by this contract nor can we rebate any part of the fee specified in this Employment Contract.

Copy of the contract: We must give you a true copy of this Employment Contract at the time you sign it.

LIMITATIONS OF PUBLIC ADJUSTERS:

We are not allowed:

- to solicit your employment between 8:00 p.m. and 8:00 a.m.
- to solicit your employment if you have already hired or contracted with another public adjuster.
- to have any interest whatsoever in any construction, salvage, or appraisal business.
- to represent both an insurer and an insured at the same time.
- to pay anything of value to any person as an inducement to refer business to us.
- to share our fee, except with another licensed Public Adjuster.
- to advise you on any question of law.
- to advance any monies to you before settlement of the loss, where such amount would be included in the final settlement.
- to make false statements about an insurance company or its representatives.

We must:

- sign this Contract.
- inform you that we do not represent any insurance company or any insurance company adjusting firm.

(2) On side two:

***NAME OF LICENSED PUBLIC ADJUSTER
ADDRESS
TELEPHONE NUMBER**

Names of individual public
Adjuster licensee(s) to appear
here

**READ BOTH SIDES BEFORE SIGNING (18 point bookman type)
PUBLIC ADJUSTER EMPLOYMENT CONTRACT**

To the Interested Insurance Companies and Others Whom it May Concern: I/we retain _____ to act
(name of public adjuster)

as my/our public adjuster(s) and to advise and assist in the adjustment and settlement of my/our _____ loss at
(type)

_____ which occurred on or
(address)

about _____. In consideration for these services, I/we hereby
(date)

assign out of the monies due or to become due from said Insurance Companies on account of the said loss a sum equivalent to _____ % percent of the amount of the loss when adjusted with the Insurance Companies or otherwise recovered.

I HAVE READ THE INFORMATION ON BOTH SIDES OF THIS CONTRACT (18 point bookman type)

(date) Signed:

(signature of insured)

(signature of insured)

(name)

(address)

(city & state)

Agreed to:

(name of individual or firm licensee)

By:

(signature of Public Adjuster)

This form is in compliance with Section 38a-788-6 of the Regulations of the Connecticut Insurance Department. This form must be signed by the licensed Public Adjuster and by Insured.

*The name of the licensee must appear here. If you operate as a firm or on behalf of a firm, show name of firm licensee here and names of all individual licensees in designated area.

(Effective September 25, 1992; transferred June 22, 1995)

Sec. 38a-788-7. Records: contracts

(a) All public adjusters shall maintain an office which shall contain the records of all documents pertaining to the settlement of the claim and files of all clients and said records shall be available for inspection by any duly authorized Examiner or employee of the Insurance Department. Such record will be kept by the public adjuster for a period of at least 5 years following the ending of the contracted employment period.

(b) All employment contracts used by public adjusters to be valid shall be signed by an insured and property owner of the property involved, or their duly authorized agent or representative.

(Effective September 25, 1992; transferred June 22, 1995)

Sec. 38a-788-8. Compensation

No public adjuster shall receive compensation in excess of 10% of the actual or final settlement of a loss covered by the employment contract.

(Effective September 25, 1992; transferred June 22, 1995)

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Conduct of Motor Vehicle Physical Damage Appraisers

Sec. 38a-790-1. Definitions

As used in sections 38a-790-2 to 38a-790-8 inclusive: (1) "Appraiser" means a motor vehicle physical damage appraiser licensed under the provisions of section 38a-790 of the 1969 supplement to the general statutes; (2) "repair shop" means any location licensed by the motor vehicle department under section 14-52 of said supplement except a "limited repairer."

(Effective September 25, 1992)

Sec. 38a-790-2. Display of license

Each appraiser, while engaged in appraisal duties, shall carry the license issued to him by the insurance department and shall display it, upon request, to an owner whose vehicle is being inspected, to the repair shop representative involved or to any authorized representative of the insurance department.

(Effective September 25, 1992)

Sec. 38a-790-3. Agreement on repair price

An appraiser may agree on a price for repairing a damaged motor vehicle only with a repair shop, as so defined, unless the damaged vehicle is located and will be repaired outside of the state of Connecticut.

(Effective September 25, 1992)

Sec. 38a-790-4. Copy of appraisal left with repair shop

The appraiser shall leave a legible copy of his appraisal with the repair shop selected to make the repairs, which appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. All unrelated or old damage should be clearly indicated on the appraisal.

(Effective September 25, 1992)

Sec. 38a-790-5. Competitive estimates

If the appraiser and the repair shop fail to agree on a price for repairs, the appraiser shall not obtain a competitive estimate from another repair shop unless the owner of such other shop, or his authorized agent, has inspected the vehicle. No such competitive estimates shall be obtained by the use of photographs, telephone calls or in any manner other than a personal inspection.

(Effective September 25, 1992)

Sec. 38a-790-6. Appraiser not to request specified shop

No appraiser shall request that appraisals or repairs be made in a specified repair shop or shops.

(Effective September 25, 1992)

Sec. 38a-790-7. Reinspection on request for supplementary allowances

Every appraiser shall reinspect damaged vehicles when supplementary allowances are requested by repair shops.

(Effective September 25, 1992)

Sec. 38a-790-8. Code of ethics

Every appraiser shall: (1) Conduct himself in such a manner as to inspire public confidence by fair and honorable dealings; (2) approach the appraisal of damaged property without prejudice against, or favoritism toward, any party involved in order

to make fair and impartial appraisals; (3) disregard any efforts on the part of others to influence his judgment in the interest of the parties involved; (4) prepare an independent appraisal of damage. No appraiser shall: (A) Receive directly or indirectly any gratuity or other consideration in connection with his appraisal services from any person except his employer or, if self-employed, his customer; (B) traffic in automobile salvage if such salvage is obtained in any way as a result of appraisal services rendered by him.

(Effective September 25, 1992)

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Casualty Adjusters

Sec. 38a-792-1. Adjusters required to be licensed

Adjusters of casualty claims requiring a license under section 38a-792 of the general statutes shall include the following: (a) All adjusters who settle personal injury or death claims arising out of automobile accidents; (b) all adjusters settling claims arising out of premises/operations liability insurance policies; (c) all adjusters handling claims arising under the workers' compensation law or otherwise covering the relationship between master and servant; (d) all adjusters handling property damage claims, including automobile collision losses; (e) all adjusters handling personal injury or death cases arising out of the violation of any common law or statutory duty not included in the above classes.

(Effective December 21, 1992)

Sec. 38a-792-2. Adjusters not required to be licensed

No fire insurance adjuster need be licensed. No life insurance adjuster need be licensed.

(Effective December 21, 1992)

Sec. 38a-792-3. Settlement of small property damage losses by agents

Any licensed agent of any insurance company who has authority to settle losses not exceeding one thousand five hundred dollars when such losses are property damage losses need not be licensed under section 38a-792 of the general statutes so long as he is licensed as an insurance agent.

(Effective December 21, 1992)

Sec. 38a-792-4. National standards

Except to the extent that they may be modified or extended by state statutes or regulations, casualty adjusters, in respect to their rights and duties in the business of adjusting insurance claims, shall be guided by the Connecticut Unfair Insurance Practices Act, Section 38a-816 (6) of the General Statutes, the regulations implementing its provisions, and the Code of Ethics as established by the National Association of Independent Insurance Adjusters, as amended from time to time.

(Effective December 21, 1992)

Sec. 38a-792-5. Notice of offer of compromise or rejection of claim

In view of the fact that the statute of limitations applies on the time for suit in negligence cases, it is suggested that, even if there might be no legal duty on the part of an adjuster so to inform the claimant, nevertheless in personal injury cases if the adjuster has interviewed the claimant within thirty days before the expiration of the statute of limitations without a settlement, fair practice and public ethics require that the adjuster should not mislead the claimant into believing that there might be a settlement prior to the expiration of the statute of limitations, and notice of an offer of compromise or rejection of claim should be definite.

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Sale of Insurance Policies by Car Rental Agencies

Sec. 38a-799-1. Definitions

As used in sections 38a-799-1 through 38a-799-9, inclusive, of the Regulations of Connecticut State Agencies:

(1) “Applicant” means a rental company seeking a permit from the commissioner to sell insurance in conjunction with the rental of vehicles;

(2) “Commissioner” means the Insurance Commissioner of the State of Connecticut;

(3) “Calendar quarter” means a three month period beginning on January 1, April 1, July 1 and October 1 of each year.

(4) “Department” means the Insurance Department of the State of Connecticut;

(5) “Permit” means a certificate of authority granted to a rental company by the commissioner authorizing such rental company to offer certain kinds of insurance in conjunction with the rental of vehicles;

(6) “Permittee” means a rental company authorized, pursuant to sections 38a-799-1 through 38a-799-9, inclusive, of the Regulations of Connecticut State Agencies, to sell the categories of insurance enumerated in subsection (b) of section 1 of Public Act 99-127 in connection with the rental of vehicles;

(7) “Rental agreement” means rental agreement as defined by section 1 of Public Act 99-127;

(8) “Rental company” means rental company as defined by section 1 of Public Act 99-127;

(9) “Renter” means renter as defined by section 1 of Public Act 99-127;

(10) “Vehicle” means vehicle as defined by section 1 of Public Act 99-127;

(Adopted effective June 29, 2000)

Sec. 38a-799-2. Categories

(a) No rental company may offer for sale any categories of insurance products other than the categories set forth in subsection (b) of section 1 of Public Act 99-127.

(b) No rental company may offer for sale any insurance products unless such products are issued by an insurance company authorized to do business in this state and unless policy forms and premium rates for such products have been filed by such insurance company with, or have been approved by, the commissioner in accordance with the provisions of Title 38a of the general statutes.

(Adopted effective June 29, 2000)

Sec. 38a-799-3. Requirements for a permit

(a) The commissioner may issue to a rental company that has complied with sections 38a-799-1 through 38a-799-9, inclusive, of the Regulations of Connecticut State Agencies a permit authorizing the rental company to offer insurance coverage for sale in connection with the rental of vehicles.

(b) An applicant for a permit shall file with the commissioner (1) a written application for a permit on a form approved by the commissioner and signed by an officer, partner, owner or principal of the applicant; (2) a list of all rental locations within this state in which the applicant conducts business and in which insurance will be offered; (3) any and all appointment applications with each authorized insurance company that the applicant will represent; and (4) the fee specified in section 38a-11 of the Connecticut General Statutes. Permittees shall notify the commissioner, in writing, of any change in the information provided pursuant to

subdivisions (1), (2) and (3) of this subsection no later than thirty days after the date of such change.

(c) No permit shall be issued or renewed by the commissioner unless the applicant submits all the documentation set forth in subsection (b) of this section and the fees required under section 38a-11 of the Connecticut General Statutes.

(d) A rental company granted a permit from the commissioner shall maintain a list of all employees who engage in insurance activities on its behalf. Such list shall be updated every time that the rental company trains newly hired employees by conducting a training session required pursuant to section 38a-799-6 of the Regulations of Connecticut State Agencies or at the beginning of every calendar quarter, whichever is earlier. Such list shall contain an employee's name, social security number, date of hiring, date in which training took place and, if applicable, date of termination of employment.

(e) A rental company shall maintain a copy of all policy forms applicable to the insurance products available for sale through the rental company and a record of the relevant period in which such forms were available.

(f) A rental company shall maintain a copy of the outline, description and summary of a training program that meets the requirements of section 38a-799-5 of the Regulations of Connecticut State Agencies.

(Adopted effective June 29, 2000)

Sec. 38a-799-4. Conditions

(a) No permittee may offer any insurance coverage under sections 38a-799-1 through 38a-799-9 of the Regulations of Connecticut State Agencies unless the underlying period of the rental agreement is sixty consecutive days or less.

(b) No permittee may offer any insurance coverage unless such permittee holds a direct appointment, in writing, by an insurance company authorized to transact business in this state, to solicit, negotiate or effect contracts of insurance on behalf of such insurance company.

(c) A permittee shall maintain in plain sight at every rental location where insurance coverage is offered, and give to all prospective renters who elect to purchase optional insurance coverage, before insurance coverage is effected, brochures or other written material that summarize, clearly and correctly in plain language consistent with the provisions of chapter 699a of the general statutes, (1) all terms, conditions and exclusions, if any, of the coverage offered, including the identity of the insurance company that underwrites the coverage provided and the process for filing a claim in the event of a loss to the renters who elect to purchase such coverage; (2) the price, benefits, advantages and limitations of the coverage offered; (3) that the insurance being offered to renters may duplicate coverage already provided by a renter's personal automobile insurance policy or by another source of coverage; and (4) that the purchase by the renter of any kind of insurance offered pursuant to sections 38a-799-1 through 38a-799-9 of the Regulations of Connecticut State Agencies is not required in order for a renter to rent a vehicle.

(d) A rental agreement shall contain, or have attached thereto, in ten point type or larger, a summary of the following information: (1) terms, conditions and exclusions, if any, of the coverage offered, including the identity of the insurance company underwriting the coverage provided and the process for filing a claim in the event of a loss to the renters who elect to purchase such coverage; (2) the price charged for insurance and the amount of coverage being purchased; (3) that the insurance being offered to renters may duplicate coverage already provided by a renter's personal automobile insurance policy or by another source of coverage; and (4) that

the purchase by the renter of any kind of insurance offered pursuant to the rental agreement is not required in order for a renter to rent a vehicle.

(e) Cost for insurance shall be itemized separately in the rental agreement or may be contained in a separate invoice distinct from the rental agreement and signed by a representative of the rental company and by the renter.

(f) The rental company shall give to renters a copy of the rental agreement and, if applicable, of the separate invoice showing the insurance products that the renter has opted to purchase and the coverage to which the renter is entitled. Such copies shall be signed by a representative of the rental company and shall be conclusive proof of insurance coverage thereof.

(Adopted effective June 29, 2000)

Sec. 38a-799-5. Training

(a) Each rental company offering insurance to renters pursuant to sections 38a-799-1 through 38a-799-9 of the Regulation of Connecticut State Agencies shall conduct a training program for all employees who will act on behalf of the rental company with respect to the marketing of insurance products to prospective renters.

(b) Each employee who will act on behalf of the rental company with respect to the marketing of insurance to renters shall receive instruction about the categories of insurance that the rental company offers for sale. Such instruction shall (1) impart a general knowledge of all the terms used in the insurance contracts marketed to renters; (2) provide a general understanding of the nature, extent of coverage, conditions and exclusions of the insurance products being offered; (3) provide instructions to the employees to acknowledge to prospective renters that optional insurance coverages are not required in order to rent a vehicle; (4) provide instructions to employees to acknowledge to prospective renters that the insurance offered may duplicate existing coverage; and (5) provide instructions to employees that they may not hold themselves or the rental company out as licensed insurance producers or agents.

(Adopted effective June 29, 2000)

Sec. 38a-799-6. Advertising

No rental company granted a permit by the commissioner pursuant to sections 38a-799-1 through 38a-799-9, inclusive, of the Regulations of Connecticut State Agencies shall advertise, represent, or otherwise hold itself out as a licensed insurance producer or agent. No employee acting on behalf of a rental company with regard to the sale of insurance products to renters may advertise, represent or otherwise hold himself out as an insurance producer or agent, unless such employee holds a valid license in this state authorizing him to act as a producer.

(Adopted effective June 29, 2000)

Sec. 38a-799-7. Compensation

No employee of a rental company may directly receive additional compensation, fees or commissions dependent on the premium received for placing insurance under the terms of the rental company's permit, except that a rental company may include the sale of insurance products in an overall performance compensation incentive plan for employees.

(Adopted effective June 29, 2000)

Sec. 38a-799-8. Records

(a) All records pertaining to the transaction of insurance by a rental company shall be retained by the rental company for a period of not less than three years

and shall be made available and open for inspection to the commissioner or his representatives at any time during normal business hours.

(b) The commissioner may, at any time, require such information as the commissioner deems necessary with respect to the business methods and insurance transactions of a rental company granted a permit under sections 38a-799-1 through 38a-799-9 inclusive of the Regulations of Connecticut State Agencies. Any information requested by the commissioner pursuant to this subsection shall be furnished by the rental company not later than fifteen days after receiving a written request thereof.

(Adopted effective June 29, 2000)

Sec. 38a-799-9. Penalties

(a) The commissioner, after reasonable notice to and hearing of any rental company granted a permit under sections 38a-799-1 through 38a-799-9 inclusive of the Regulations of Connecticut State Agencies, may suspend or revoke the permit for cause shown. In addition to or in lieu of suspension or revocation, the commissioner may impose a fine not to exceed the fine amount established in section 1 of public act 99-127.

(b) Any person aggrieved by the action of the commissioner in revoking, suspending or refusing to grant or reissue a permit or in imposing a fine may appeal therefrom, in accordance with the provisions of section 4-183 of the general statutes, except venue for such appeal shall be in the judicial district of Hartford. Appeals under this section shall be privileged in respect to the order of trial assignment.

(c) Pursuant to section 4-183 of the general statutes, the filing of an appeal under this section shall not, of itself, stay enforcement of the department's decision. An application for a stay may be made to the department, to the court or to both. A stay, if granted, shall be on appropriate terms.

(Adopted effective June 29, 2000)

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Unfair Insurance Practices: Advertisements of Accident and Sickness Insurance

Sec. 38a-819-1. Purpose

The purpose of these regulations is to assure truthful and adequate disclosure of all material and relevant information in the advertising of accident and sickness insurance. This purpose is intended to be accomplished by the establishment of, and adherence to, certain minimum standards and guidelines of conduct in the advertising of accident and sickness insurance in a manner which prevents unfair competition among insurers and is conducive to the accurate presentation and description to the insurance buying public of a policy of such insurance offered through various advertising media.

(Effective September 25, 1992)

Sec. 38a-819-2. Applicability

A. These regulations shall apply to any accident and sickness insurance “advertisement” as that term is hereinafter defined in Sections 38a-819-3A, G, H, and I, unless otherwise specified in these regulations, intended for presentation, distribution or dissemination in this state when such presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer, agent, broker, or solicitor as those terms are defined in the Insurance Code of this State and these rules.

B. Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are so advertised.

(Effective September 25, 1992)

Sec. 38a-819-3. Definitions

A. An “advertisement” for the purpose of these regulations shall include: (1) printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards and similar displays; and (2) descriptive literature and sales aids of all kinds issued by an insurer, agent or broker for presentation to members of the insurance buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and (3) prepared sales talks, presentations and material for use by agents, brokers and solicitors.

B. “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 an indemnity, reimbursement service or prepaid basis.

C. “Insurer” for the purpose of these regulations shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health maintenance organization, and any other legal entity engaged in the advertisement of a policy as “policy” is herein defined.

D. “Exception” for the purpose of these regulations shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

E. “Reduction” for the purpose of these regulations 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 not been used.

F. "Limitation" for the purpose of these regulations shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

G. "Institutional Advertisement" for the purpose of these regulations shall mean an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of accident and sickness insurance, or the promotion of the insurer.

H. "Invitation to Inquire" for the purpose of these regulations shall mean an advertisement having as its objective the creation of a desire to inquire further about the product and which is limited to a brief description of the loss for which the benefit is payable, and which may contain: (1) The dollar amount of benefit payable, and/or (2) the period of time during which the benefit is payable; provided the advertisement does not refer to cost. An advertisement which specifies either the dollar amount of benefit payable or the period of time during which the benefit is payable shall contain a provision in effect as follows:

"For costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the policy may be continued in force, see your agent or write to the company."

I. "Invitation to Contract" for the purpose of these regulations shall mean an advertisement which is neither an invitation to inquire nor an institutional advertisement.

(Effective September 25, 1992)

Sec. 38a-819-4. Method of disclosure of required information

All information required to be disclosed by these regulations 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 advertisement so as to be confusing or misleading.

(Effective September 25, 1992)

Sec. 38a-819-5. Form and content of advertisements

A. The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

B. 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.

C. An offer in an advertisement of free inspection of policy or offer of a premium refund or offer to inquire is not a cure for misleading or deceptive statements contained in such advertisement.

(Effective September 25, 1992)

Sec. 38a-819-6. Advertisements of benefits payable, losses covered or premiums payable

A. **Deceptive words, phrases, or illustrations prohibited.** (1) No advertisement shall omit information or use words, phrases, statements, references or illustrations

if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied does not remedy misleading statements.

(2) No advertisement shall contain or use words or phrases such as “all,” “full,” “complete,” “comprehensive,” “unlimited,” “up to,” “as high as,” “this policy will help pay your hospital and surgical bills,” “this policy will help fill some of the gaps that Medicare and your present insurance leave out,” “this policy will help to replace your income” (when used to express loss of time benefits), or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

(3) An advertisement shall not contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a “benefit builder” or stating “even pre-existing conditions are covered after two years.” Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

(4) No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as “tax free,” “extra cash,” “extra income,” “extra pay,” or substantially similar words or phrases because such words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

(5) No advertisement of a hospital or other similar facility confinement benefit shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement. When the policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

(6) No advertisement of a policy covering only one disease or a list of specified diseases shall 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.

(7) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to, or substantially similar to the following: “THIS IS A LIMITED POLICY,” “THIS IS A CANCER ONLY POLICY.”

(8) An advertisement of a direct response insurance product shall not imply that because “no insurance agent will call and no commissions will be paid to agents” that it is “a low cost plan,” or use other similar words or phrases because the cost of advertising and servicing such policies is a substantial cost in the marketing of a direct response insurance product.

B. Exceptions, reductions and limitations. (1) When an advertisement refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the 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 or tendency to mislead or deceive.

(2) When a policy contains a waiting, elimination, probationary or similar 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 loss, an advertisement which is subject to the requirements of the preceding paragraph shall disclose the existence of such periods.

(3) An advertisement shall not use the words “only,” “just,” “merely,” “minimum,” or similar words or phrases to describe the applicability of any exceptions and reductions, such as: “This policy is subject to the following minimum exceptions and reductions.”

C. Pre-existing conditions. (1) An advertisement which is subject to the requirements of § 38a-819-6 B shall, in negative terms, 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. The use of the term “pre-existing condition” without an appropriate definition or description shall not be used.

(2) When a policy does not cover losses resulting from 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 rule prohibits the use of the phrase “no medical examination required” and phrases of similar import but does not prohibit explaining “automatic issue.” If an insurer requires a medical examination for a specified policy, the advertisement if it is an invitation to contract shall disclose that a medical examination is required.

(3) When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct response insurance product, such application form shall contain a question or statement which reflects the pre-existing condition provisions of the policy immediately preceding the blank space for the applicant’s signature. For example, such an application form shall contain a question or statement substantially as follows:

“Do you understand that this policy will not pay benefits during the first ____ year(s) after the issue date for a disease or physical condition which you now have or have had in the past?

YES”

Or substantially the following statement:

“I understand that the policy applied for will not pay benefits for any loss incurred during the first ____ year(s) after the issue date on account of disease or physical condition which I now have or have had in the past.”

(Effective September 25, 1992)

Sec. 38a-819-7. Necessity for disclosing policy provisions relating to renewability, cancellability and termination

When an advertisement which is an invitation to contract refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it 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.

(Effective September 25, 1992)

Sec. 38a-819-8. Photographs

The use of the following photographs, illustrations or depictions shall not be used in a manner that has the capacity, tendency or effect of being misleading or deceptive: (1) hospitalized victims or patients; (2) ambulances or emergency vehicles; (3) medical instruments, facilities or personnel; (4) injured persons; (5) any photograph or illustration that detracts or unduly emphasizes the risks covered by a particular policy; (6) any other photograph, illustration or depiction that tends to be misleading or deceptive.

(Effective September 25, 1992)

Sec. 38a-819-9. Testimonials or endorsements by third parties

A. 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 statement, is subject to all the provisions of these rules.

B. If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." The provisions of this subsection do not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements remove the filming or recording from the category of an unsolicited testimonial and require disclosure of such compensation. The provisions of this subsection do not apply to an institutional advertisement which has as its sole purpose the promotion of the insurer.

C. An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement.

D. When a testimonial refers to benefits received under a policy, the specific claim data, including claim number, date of loss, and other pertinent information shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

(Effective September 25, 1992)

Sec. 38a-819-10. Use of statistics

A. 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 use irrelevant facts and 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, and when applicable to other policies or plans shall specifically so state.

B. An advertisement shall not represent or imply that claim settlements by the insurer are “liberal” or “generous,” or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

C. The source of any statistics used in an advertisement shall be identified in such advertisement.

(Effective September 25, 1992)

Sec. 38a-819-11. Identification of plan or number of policies

A. When a choice of the amount of benefits is referred to, an advertisement which is an invitation to contract 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 selected.

B. When an advertisement which is an invitation to contract 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.

(Effective September 25, 1992)

Sec. 38a-819-12. Disparaging comparisons and statements

An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers and shall not disparage competitors, their policies, services or business methods and shall not disparage or unfairly minimize competing methods of marketing insurance.

(Effective September 25, 1992)

Sec. 38a-819-13. Jurisdictional licensing and status of insurer

A. 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.

B. An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed, or accredited by any division or agency of this state or the United States Government unless such is the fact.

(Effective September 25, 1992)

Sec. 38a-819-14. Identity of insurer

A. The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement which is an invitation to contract. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

B. No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color or other characteristics

are so similar to combination of words, symbols, or physical materials used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state, or federal government.

(Effective September 25, 1992)

Sec. 38a-819-15. Group or quasi-group implications

An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact.

(Effective September 25, 1992)

Sec. 38a-819-16. Introductory, initial or special offers

A. (1) an advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not contain phrases describing an enrollment period as “special,” “limited,” or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising accident and sickness insurance.

(2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than six months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application which shall be not less than ten days and not more than forty days from the date that such enrollment period is advertised for the first time. The provisions of this subsection apply to all advertising media, i.e., mail, newspapers, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the Insurance Code for group, blanket or franchise insurance. The phrase “any one insurer” includes all the affiliated companies of a group of insurance companies under common management or control.

(3) The provisions of this subsection prohibit any statement 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.

(4) The phrase “a particular insurance product” in ¶ (2) of this section means an insurance policy which provides substantially different benefits than those contained in any other policy. Different terms of renewability, an increase or decrease in the dollar amounts of benefits, an increase or decrease in any elimination period of waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

B. An advertisement shall not offer a policy which utilizes a reduced initial premium rate.

3. Special awards, such as a “safe drivers’ award” shall not be used in connection with advertisements of accident or accident and sickness insurance.

(Effective September 25, 1992)

Sec. 38a-819-17. Statements about an insurer

An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation.

(Effective September 25, 1992)

Sec. 38a-819-18. Enforcement procedures

A. **Advertising file.** Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its 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 either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

B. **Certificate of compliance.** Each insurer required to file an Annual Statement which is now or which hereafter becomes subject to the provisions of these regulations must file with this Department with its Annual Statement a Certificate of Compliance 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 these regulations and the insurance laws of this State as implemented and interpreted by these regulations.

(Effective September 25, 1992)

Sec. 38a-819-19. Severability provision

If any section or portion of a section of these regulations or the applicability thereof to any person or circumstance is held invalid by a court, the remainder of the regulations, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

(Effective September 25, 1992)

Sec. 38a-819-20. Filing for prior review

The Commissioner may, at his discretion, after reasonable notice to the insurer involved, require the filing with this Department, for review prior to use, of all advertising material proposed for use by an insurer as defined in § 38a-819-3 C herein. Such advertising material must be filed by the insurer with this Department not less than 30 days prior to the date the insurer desires to use the advertisement.

(Effective September 25, 1992)

Unfair Insurance Practices: Advertisements of Life Insurance**Sec. 38a-819-21. Purpose**

The purpose of these regulations is to set forth minimum standards and guidelines to assure a full and truthful disclosure to the public of all material and relevant information in the advertising of life insurance policies and annuity contracts.

(Effective September 25, 1992)

Sec. 38a-819-22. Definitions

For the purpose of these regulations:

A. "Policy" shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider, or endorsement which provides for life insurance or annuity benefits.

B. "Insurer" shall include any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's, fraternal benefit society, and any other legal entity which is defined as an "insurer" in the Insurance Code of this State or issues life insurance or annuities in this state and is engaged in the advertisement of a policy.

C. "Advertisement" shall be material designed to create public interest in life insurance or annuities or in an insurer, or to induce the public to purchase, increase, modify, reinstate, or retain a policy including:

1. Printed and published material, audiovisual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio and television scripts, billboards, and similar displays;

2. Descriptive literature and sales aids of all kinds issued by an insurer or agent, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters;

3. Material used for the recruitment, training, and education of an insurer's sales personnel, agents, solicitors, and brokers which is designed to be used or is used to induce the public to purchase, increase, modify, reinstate, or retain a policy;

4. Prepared sales talks, presentations, and material for use by sales personnel, agents, solicitors, and brokers.

D. "Advertisement" for the purpose of these regulations shall not include:

1. Communications or materials used within an insurer's own organization and not intended for dissemination to the public;

2. Communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate, or retain a policy;

3. A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged, provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage.

(Effective September 25, 1992)

Sec. 38a-819-23. Applicability

A. These regulations shall apply to any life insurance or annuity advertisement intended for dissemination in this state.

B. Every insurer shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the insurer.

(Effective September 25, 1992)

Sec. 38a-819-24. Form and content of advertisements

A. Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive.

Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression

that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

B. No advertisement shall use the terms “investment,” “investment plan,” “founder’s plan,” “charter plan,” “expansion plan,” “profit,” “profits,” “profit sharing,” “interest plan,” “savings,” “savings plan,” or other similar terms in connection with a policy in a context or under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser or prospective purchaser of such policy to believe that he will receive, or that it is possible that he will receive, something other than a policy or some benefit not available to other persons of the same class and equal expectation of life.

(Effective September 25, 1992)

Sec. 38a-819-25. Disclosure requirements

A. The information required to be disclosed by these regulations shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the rest of the advertisement so as to be confusing or misleading.

B. No advertisement shall omit material information or use words, phrases, statements, references, or illustrations if such omission or such use has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable, or state or federal tax consequences. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale, or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

C. In the event an advertisement uses “Non-Medical,” “No Medical Examination Required,” or similar terms where issue is not guaranteed, such terms shall be accompanied by a further disclosure of equal prominence and in juxtaposition thereto to the effect that issuance of the policy may depend upon the answers to the health questions.

D. An advertisement shall not use as the name or title of a life insurance policy any phrase which does not include the words “life insurance” unless accompanied by other language clearly indicating it is life insurance.

E. An advertisement shall prominently describe the type of policy advertised.

F. An advertisement of an insurance policy marketed by the direct response techniques shall not state or imply that because there is no agent or commission involved there will be a cost saving to prospective purchasers unless such is the fact. No such cost savings may be stated or implied without justification satisfactory to the Insurance Commissioner prior to use.

G. An advertisement for a policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or increases with age or duration, such fact shall be prominently disclosed.

H. An advertisement for a policy with non-level premiums shall prominently describe the premium changes.

I. **Dividends.** 1. An advertisement shall not utilize or describe dividends in a manner which is misleading or has the capacity or the tendency to mislead.

2. An advertisement shall not state or imply that the payment or amount of dividends is guaranteed. If dividends are illustrated, they must be based on the insurer’s current dividend scale and the illustration must contain a statement to the effect that they are not to be construed as guarantees or estimates of dividends to be paid in the future.

3. An advertisement shall not state or imply that illustrated dividends under a participating policy and/or pure endowments will be or can be sufficient at any future time to assure, without the further payment of premiums, the receipt of benefits, such as a paid-up policy, unless the advertisement clearly and precisely explains (a) what benefits or coverage would be provided at such time and (b) under what conditions this would occur.

J. An advertisement shall not state that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company.

K. Testimonials or endorsements by third parties. 1. Testimonials used in advertisements must be genuine; represent the current opinion of the author; be applicable to the policy advertised, if any; and be accurately reproduced. In using a testimonial the insurer makes as its own all of the statements contained therein, and such statements are subject to all the provisions of these regulations.

2. If the individual making a testimonial or an endorsement has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, or receives any benefit directly or indirectly other than required union scale wages, such fact shall be disclosed in the advertisement.

3. An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by a group of individuals, society, association, or other organization unless such is the fact and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial is owned, controlled, or managed by the insurer, or receives any payment or other consideration from the insured for making such endorsement or testimonial, such fact shall be disclosed in the advertisement.

L. An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any such statistics used in an advertisement shall be identified therein.

M. Introductory, initial, or special offers and enrollment periods. 1. An advertisement of an individual policy or combination of such policies shall not state or imply that such policy or combination of such policies is an introductory, initial, or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not describe an enrollment period as "special" or "limited" or use similar words or phrases in describing it when the insurer uses successive enrollment periods as its usual method of marketing its policies.

2. An advertisement shall not state or imply 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.

3. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium shall be followed by an asterisk or other appropriate symbol which refers the reader to that specific portion of the advertisement which contains the full rate schedule for the policy being advertised.

4. An enrollment period during which a particular insurance policy may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than six months between the close of the immediately

preceding enrollment period for the same policy and the opening of the new enrollment period. The advertisement shall specify the date by which the applicant must mail the application, which shall be not later than ten days and not more than forty days on which such enrollment period is advertised for the first time. This rule applies to all advertising media—i.e., mail, newspapers, radio, television, magazines, and periodicals—used by any one insurer. The phrase “any one insurer” includes all the affiliated companies of a group of insurance companies under common management or control. This rule does not apply to the use of a termination or cutoff date beyond which an individual application for a guaranteed issue policy will not be accepted by an insurer in those instances where the application has been sent to the applicant in response to his request. It is also inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the Insurance Code for group, blanket, or franchise insurance. In cases where an insurance product is marketed on a direct mail basis to prospective insureds by reason of some common relationship with a sponsoring organization, this rule shall be applied separately to each such sponsoring organization.

N. An advertisement of a particular policy shall not state or imply that prospective insureds shall be or become members of a special class, group, or quasi-group and as such enjoy special rates, dividends, or underwriting privileges, unless such is the fact.

O. An advertisement shall not make unfair or incomplete comparisons of policies, benefits, dividends, or rates of other insurers. An advertisement shall not falsely or unfairly describe other insurers, their policies, services, or methods of marketing.

(Effective September 25, 1992)

Sec. 38a-819-26. Identity of insurer

A. The name of the insurer shall be clearly identified and, if any specific individual policy is advertised, it shall be identified either by form number or other appropriate description. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol, or other device or reference without disclosing the name of the insurer, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy.

B. No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color, or other characteristics are so similar to a combination of words, symbols, or physical materials used by a governmental program or agency or otherwise appear to be of such a nature that they tend to mislead prospective insureds into believing that the solicitation is in some manner connected with such governmental program or agency.

(Effective September 25, 1992)

Sec. 38a-819-27. Jurisdictional licensing and status of insurer

A. 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 such limits.

B. An advertisement may state that an insurer is licensed in the state where the advertisement appears, provided it does not exaggerate such fact or suggest or imply that competing insurers may not be so licensed.

C. An advertisement shall not create the impression that the insurer, its financial condition or status, the payment of its claim, or the merits, desirability, or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, such fact may be stated if the entity authorizes its recommendation or endorsement to be used in an advertisement.

(Effective September 25, 1992)

Sec. 38a-819-28. Statements about the insurer

An advertisement shall not contain statements, pictures, or illustrations which are false or misleading, in fact or by implication, with respect to the assets, liabilities, insurance in force, corporate structure, financial condition, age, or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly defines the scope and extent of the recommendation.

(Effective September 25, 1992)

Sec. 38a-819-29. Enforcement procedure

A. Each insurer shall maintain at its home or principal office a complete file containing a specimen copy of every printed, published, or prepared advertisement of its individual policies and specimen copies of typical printed, published, or prepared advertisements of its blanket, franchise, and group policies, hereafter disseminated in this state, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to inspection by this Department. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

B. Each insurer subject to the provisions of these regulations shall file with this Department with its Annual Statement a certificate of compliance 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 or on behalf of the insurer in this state during the preceding statement year, or during the portion of such year when these rules were in effect, complied or were made to comply in all respects with the provisions of these regulations and the insurance laws of this state as implemented and interpreted by these regulations.

(Effective September 25, 1992)

Sec. 38a-819-30. Filing for prior review

The Commissioner may, at his discretion, after reasonable notice to the insurer involved, require the filing with this Department, for review prior to use, of all advertising material proposed for use by an insurer. Such advertising material must be filed by the insurer with this Department not less than thirty days prior to the date of the insurer desires to use the advertisement.

(Effective September 25, 1992)

Sec. 38a-819-31. Severability provision

If any section or portion of a section of these regulations or the applicability thereof to any person or circumstance is held invalid by a court, the remainder of the regulations, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

(Effective September 25, 1992)

Life Insurance Solicitation

Sec. 38a-819-32. Authority

This regulation is adopted and promulgated by the Insurance Commissioner pursuant to Section 38-64 of the General Statutes.

(Effective September 25, 1992)

Sec. 38a-819-33. Purpose

(A) The purpose of this regulation 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 does not prohibit the use of additional material which is not in violation of this regulation or any other Connecticut statute or regulation.

(Effective September 25, 1992)

Sec. 38a-819-34. Scope

(A) Except as hereafter exempted, this regulation shall apply to any solicitation, negotiation, or procurement of life insurance occurring within this state. This regulation shall apply to any issuer of life insurance contracts including fraternal benefit societies.

(B) Unless otherwise specifically included, this regulation 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.

(Effective September 25, 1992)

Sec. 38a-819-35. Definitions

For the purposes of this regulation, 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 to this regulation or language approved by the Insurance Commissioner.

(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 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 over the respective periods stipulated in Step 1. 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 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 percent interest compounded annually to the end of the tenth and twentieth policy years respectively.

2. Divide each accumulation of Step 1 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 over the respective periods stipulated in Step 1. 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 a 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 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 percent interest compounded annually to the end of the period selected and add this sum to the amount determined in Step a.

c. Divide the result of Step b. (Step a. for guaranteed cost policies) by an interest factor that converts it into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in Step b. (Step a. for guaranteed cost policies) over the respective periods stipulated in Step a. 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 percent interest compounded annually to the end of the period stipulated in Step a. and dividing the result by the respective factors stated in Step c. (this amount is the annual premium payable for a level premium plan).

e. Subtract the result of Step c. from Step d.

f. Divide the result of Step e. 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 purposes 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 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 includes 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 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 thereof 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 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.

(Effective September 25, 1992)

Sec. 38a-819-36. 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 Sec. 38a-819-35 (G), items 2, 3, 4, 5a, 5b, 5c, 6, 7, 10 and 11.

(Effective September 25, 1992)

Sec. 38a-819-37. General rules

(A) Each insurer shall maintain at its home office or principal office, a complete file containing one copy of each document 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 which 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 as a single sum unless they are 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, 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.

(Effective September 25, 1992)

Sec. 38a-819-38. Failure to comply

Failure of an insurer to provide or deliver a Buyer's Guide, or a Policy Summary as provided in Sec. 38-64-36 shall constitute an omission which misrepresents the benefits, advantages, conditions, or terms of an insurance policy.

(Effective September 25, 1992)

Sec. 38a-819-39. Effective date

This regulation shall apply to all solicitations of life insurance which commence on or after January 1, 1978.

(Effective September 25, 1992)

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 which 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 for your premium dollar.

FINDING A LOW COST POLICY

After you have decided which 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.

2. **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 nonparticipating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the nonparticipating 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 a while, 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 can 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.

(Effective September 25, 1992)

Sec. 38a-819-40 to 38a-819-49. Reserved

Complaint Records of Insurance Companies

Sec. 38a-819-50. Authority

These regulations are authorized under the provisions of Section 38-64 of the General Statutes.

(Effective September 25, 1992)

Sec. 38a-819-51. Content of complaint record

Section 38a-819-55 of these regulations sets forth the minimum information required to be obtained in a person's complaint record in order for it to comply with Section 38a-816 (7) of the Connecticut General Statutes. Refinements and additions to the information specified therein may be maintained in such complaint record. Section 38a-819-56 of these regulations contains the explanation of the various headings, codes and other notations contained in Section 38a-819-55. The codes are used in order to simplify both the identification of the action underlying the complaint and the keeping of the records.

(Effective September 25, 1992)

Sec. 38a-819-52. Format of complaint record

Section 38a-819-55 of these regulations is the suggested format for the complaint record required to be maintained by Section 38a-816 (7) of the Connecticut General Statutes, and this regulation. Refinements, deviations from or additions to this suggested format are permitted so long as the minimum information contemplated by such format can be obtained for insurance department review within a reasonable time following a request therefore by an authorized representative of the department.

(Effective September 25, 1992)

Sec. 38a-819-53. Maintenance of the record

The complaint record shall be kept on a calendar year basis and the number of complaints by line of insurance, function, reason, disposition, and state of origin shall be compiled not less frequently than annually. The complaint record required

by this regulation shall be maintained on and after the date sixty days after the effective date of this regulation.

(Effective September 25, 1992)

Sec. 38a-819-54. Definitions

As used herein: (a) “person” shall have the meaning set forth in Section 38-60 of the Connecticut General Statutes; (b) “complaint” shall mean a written communication primarily expressing a grievance; (c) “insurance department complaint” shall mean a written communication regarding a complaint transmitted by the insurance department.

(Effective September 25, 1992)

Sec. 38a-819-55. Complaint record

COMPLAINT RECORD

<i>COLUMN A</i>	<i>COLUMN B</i>	<i>COLUMN C</i>	<i>COLUMN D</i>	<i>COLUMN E</i>	<i>COLUMN F</i>	<i>COLUMN G</i>	<i>COLUMN H</i>	
Company Identification Number	Function Code	Reason Code	Line Type	Company Disposition After Complaint Receipt	Date Received	Date Closed	Insurance Department Complaint	State of Origin

(Agent's Number)

(Staff Adjuster's Number)

(Independent Adjuster)

(Effective September 25, 1992)

Sec. 38a-819-56. Explanation of codes

Col. A. Company Identification Number. As noted, this refers to the identification number of the complaint and shall also include the license number of other means of identifying any licensee of the Insurance Department (such as agent, staff adjuster, or independent adjuster) that may have been involved in the complaint.

Col. B. Function Code. Complaints are to be classified by function(s) of the Company involved. Separate classifications are to be maintained for underwriting, marketing and sales, claims, policyholder service and miscellaneous.

Reason Code. Complaints are also to be classified by the nature of the complaint. The following is the classification required for each function specified above.

- 1) Underwriting
 - a) Company underwriting
 - b) Individual's application underwriting (This refers to any complaint where misrepresentations or declarations in an application for insurance resulted in company action involved in the complaint)
 - c) Cancellation
 - d) Rescission
 - e) Non-renewal
 - f) Premiums and rating
 - g) Delays
 - h) Refusal to insure
 - i) Miscellaneous (not covered by above)
- 2) Marketing and Sales

- a) General Advertising
- b) Mass marketing advertising—(advertising which is essentially directed to reach more people than in a one to one relationship)
- c) Agent handling
- d) Replacement
- e) Dividend illustration
- f) Delays
- g) Alleged misleading statement or misrepresentation
- h) Miscellaneous (not covered by above)
- 3) Claims
 - a) Claims procedure
 - b) Delays
 - c) Unsatisfactory settlements
 - d) Natural disaster adjusting (hurricane or flood situations or other situations which produce a large number of claims)
 - e) Unsatisfactory settlement offers
 - f) Denial of Claim
 - g) Miscellaneous (not covered by above)
- 4) Policyholder Service
 - (a) Failure to respond
 - (b) Delays
 - (c) Miscellaneous (not covered by above)
- 5) Miscellaneous

Col. C. Line Type. Complaints are to be classified according to the line of insurance involved, as follows:

- 1) Automobile
- 2) Fire
- 3) Homeowners—Farmowners
- 4) Crop
- 5) Inland Marine
- 6) Individual Life
- 7) Group Life
- 8) Annuities
- 9) Individual Health—Accident & Sickness
- 10) Group Health—Accident & Sickness
- 11) Workmen's Compensation
- 12) Liability Insurance Other Than Automobile
- 13) Mobile Homeowners
- 14) Miscellaneous (not covered by above)

Col. D. Company Disposition After Receipt. The complaint record shall note the disposition of the complaint.

The following examples illustrate the type of information called for but are not intended to be required language nor to exhaust the possibilities:

- 1) Corrective action was taken;
- 2) No action was deemed necessary;
- 3) Satisfactory explanation was given to the complainant.

The complaint record need not note the specific action taken with respect to the complaint, so long as the action was appropriate to the circumstances. If the company wishes, it may use a code for entries in this column.

Col. E. Date Received. This refers to the date the complaint was received.

Col. F. Date Closed. This refers to the date on which the complaint was disposed of whether by one action or a series of actions as may be present in connection with some complaints.

Col. G. Insurance Department Complaint. Complaints are to be classified as to indicate if the origin of the complaint was from an insurance department.

Col. H. Date of Origin. The complaint record should note the state from which the complaint originated.

Col. H. State of Origin. Ordinarily, this will be the state of residence of the complainant.

(Effective September 25, 1992)

Sec. 38a-819-57. Effective date

These regulations shall be effective on January 1, 1978.

(Effective September 25, 1992)

Life Insurance Illustrations

Sec. 38a-819-58. Applicability and scope

Sections 38a-819-58 to 38a-819-69, inclusive, of the regulations of Connecticut State Agencies apply to all group and individual life insurance policies and certificates except:

- (1) Variable life insurance;
- (2) Individual and group annuity contracts;
- (3) Credit life insurance; or
- (4) Life insurance policies with no illustrated death benefits on any individual exceeding \$10,000.

(Adopted effective January 1, 1999)

Sec. 38a-819-59. Definitions

As used in sections 38a-819-58 to 38a-819-69, inclusive, of the regulations of Connecticut State Agencies:

(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 Insurance Commissioner.

(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 non-guaranteed 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 non-guaranteed 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 sections 38a-819-58 to 38a-819-69, inclusive, of the regulations of Connecticut State Agencies;

(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” and “non-guaranteed elements”:

(A) “Guaranteed elements” means the premiums, benefits, values, credits or charges under a policy of life insurance that are guaranteed and determined at issue.

(B) “Non-guaranteed elements” means the premiums, benefits, values, credits or charges under a policy of life insurance that are not guaranteed or not determined at issue.

(8) “Illustrated scale” means a scale of non-guaranteed 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 non-guaranteed elements of a policy of life insurance over a period of years and that is one of the three (3) types defined in subdivisions (A) to (C), inclusive, of this subsection:

(A) “Basic illustration” means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and non-guaranteed elements.

(B) “Supplemental illustration” means an illustration furnished in addition to a basic illustration that meets the applicable requirements of sections 38a-819-58 to 38a-819-69, inclusive, of the regulations of Connecticut State Agencies and that may be presented in a format differing from the basic illustration, but may only depict a scale of non-guaranteed 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 year or more.

(10) “Illustration actuary” means an actuary meeting the requirements of Sec. 38a-819-66 of the regulations of Connecticut State Agencies 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 subsection (16) of this section, under a modified persistency rate assumption using persistency rates underlying the disciplined current scale for the first five (5) years and 100 percent policy persistency thereafter.

(12) (A) “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:

(i) Fully allocated expenses;

(ii) Marginal expenses; and

(iii) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the commissioner.

(B) 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 shall be used.

(13) “Non-term 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.

(14) "Policy owner" means the owner named in the policy or the certificate holder in the case of a group policy.

(15) "Premium outlay" means the amount of premium assumed to be paid by the policy owner or other premium payer out-of-pocket.

(16) "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.

(Adopted effective January 1, 1999)

Sec. 38a-819-60. Policies to be illustrated

(a) Each insurer marketing policies to which sections 38a-819-58 to 38a-819-69, inclusive, of the regulations of Connecticut State Agencies are 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 section, 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 section, 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 sections 38a-819-58 to 38a-819-69, inclusive, of the regulations of Connecticut State Agencies 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 non-term group life subject to sections 38a-819-58 to 38a-819-69, inclusive, of the regulations of Connecticut State Agencies 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 non-guaranteed basis appropriate to the group and the coverage. This quotation shall not be considered an illustration for purposes of sections 38a-819-58 to 38a-819-69, inclusive, of the regulations of Connecticut State Agencies 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 non-term 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 non-term group life enrollee who requests it.

(Adopted effective January 1, 1999)

Sec. 38a-819-61. General rules and prohibitions

(a) An illustration used in the sale of a life insurance policy shall satisfy the applicable requirements of sections 38a-819-58 to 38a-819-69, inclusive, of the regulations of Connecticut State Agencies, 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 subsection (c) of section 38a-819-60 of the regulations of Connecticut State Agencies;
- (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; and
- (7) Dividend option election or application of non-guaranteed 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:

- (1) Represent the policy as anything other than a life insurance policy;
 - (2) Use or describe non-guaranteed 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 non-guaranteed elements is guaranteed;
 - (4) Use an illustration that does not comply with the requirements of sections 38a-819-58 to 38a-819-69, inclusive, of the regulations of Connecticut State Agencies;
 - (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 non-guaranteed 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”; or
 - (10) Use an illustration that is not “self-supporting.”
- (c) If an interest rate used to determine the illustrated non-guaranteed elements is shown, it shall not be greater than the earned interest rate underlying the disciplined current scale.

(Adopted effective January 1, 1999)

Sec. 38a-819-62. Standards for basic illustrations

- (a) **Format.** 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-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 non-guaranteed 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 non-guaranteed.

(8) The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed 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 non-guaranteed elements shall be accompanied by a statement indicating that:

(A) The benefits and values are not guaranteed;

(B) The assumptions on which they are based are subject to change by the insurer; and

(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 non-guaranteed values, the illustration shall 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 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 non-guaranteed, 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) **Narrative Summary.** 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 non-guaranteed, 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; and

(5) A statement containing in substance the following: “This illustration assumes that the currently illustrated non-guaranteed 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.

(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 70, if applicable, on the three bases set forth in subparagraphs (A) to (C), inclusive, of this subdivision. For multiple life policies the summary shall show policy years five (5), ten (10), twenty (20) and thirty (30).

(A) Policy guarantees;

(B) Insurer’s illustrated scale;

(C) Insurer’s illustrated scale used but with the non-guaranteed elements reduced as follows:

(i) Dividends at fifty percent (50%) of the dividends contained in the illustrated scale used;

(ii) Non-guaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and

(iii) All non-guaranteed 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.

(2) In addition, if coverage would cease prior to policy maturity or age 100, the year in which coverage ceases shall be identified for each of the three (3) bases set forth in subparagraphs (A) to (C), inclusive, of subdivision (1) of this subsection.

(d) Statements. 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 section 38a-819-64 of the regulations of Connecticut State Agencies.

(1) A statement to be signed and dated by the applicant or policy owner reading as follows: “I have received a copy of this illustration and understand that any non-guaranteed 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 as follows: “I certify that this

illustration has been presented to the applicant and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration.”

(e) Tabular Detail.

(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 100, policy maturity or final expiration; and except for term insurance beyond the 20th 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; and

(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) Non-guaranteed 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 non-guaranteed elements are shown they shall be shown at the same durations as the corresponding guaranteed elements, if any. If no guaranteed benefit or value is available at any duration for which a non-guaranteed benefit or value is shown, a zero shall be displayed in the guaranteed column.

(Adopted effective January 1, 1999)

Sec. 38a-819-63. Standards for supplemental illustrations

(a) A supplemental illustration may be provided so long as:

(1) It is appended to, accompanied by or preceded by a basic illustration that complies with sections 38a-819-58 to 38a-819-69, inclusive, of the regulations of Connecticut State Agencies;

(2) The non-guaranteed 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 non-guaranteed elements are not guaranteed; and

(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.

(Adopted effective January 1, 1999)

Sec. 38a-819-64. Delivery of illustrations and record retention

(a) (1) 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 section 38a-819-62 of the regulations of Connecticut State Agencies, shall be submitted to the insurer at the time of policy application. A copy also shall be provided to the applicant.

(2) 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 conform to the requirements of sections 38a-819-58 to 38a-819-69, inclusive, of the regulations of Connecticut State Agencies, shall be labeled "Revised Illustration" and shall 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) (1) 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.

(2) 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.

(Adopted effective January 1, 1999)

Sec. 38a-819-65. Annual report; notice to policy owners

(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, interest, mortality, expense and 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; and

(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; or

(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 non-guaranteed policy elements by the insurer.

(b) If the annual report does not include an in force illustration, it shall contain the following notice displayed prominently: "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 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 subsections (a) and (b) of section 38a-819-61 of the regulations of Connecticut State Agencies and subsections (a) and (e) of section 38a-819-62 of the regulations of Connecticut State Agencies. No signature or other acknowledgment of receipt of this illustration shall be required.

(d) If an adverse change in non-guaranteed 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.

(Adopted effective January 1, 1999)

Sec. 38a-819-66. Annual certifications

(a) The board of directors of each insurer shall appoint one or more illustration actuaries.

(b) The illustration actuary shall certify that the disciplined current scale used in illustrations is in conformity with the Actuarial Standard of Practice for Compliance

with the NAIC Model Regulation on Life Insurance Illustrations promulgated by the Actuarial Standards Board, and that the illustrated scales used in insurer-authorized illustrations meet the requirements of this regulation.

(c) The illustration actuary shall:

(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) of this subsection;

(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 non-guaranteed elements illustrated for new policies are not consistent with those illustrated for similar in force policies, this shall be disclosed in the annual certification. If non-guaranteed elements illustrated for both new and in force policies are not consistent with the non-guaranteed elements actually being paid, charged or credited to the same or similar forms, this shall be disclosed in the annual certification; and

(6) Disclose in the annual certification the method used to allocate overhead expenses for all illustrations:

(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) (1) The illustration actuary shall file a certification with the board and with the commissioner:

(A) Annually for all policy forms for which illustrations are used; and

(B) Before a new policy form is illustrated.

(2) 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:

(1) That the illustration formats meet the requirements of this regulation and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary; and

(2) That the company has provided its agents with information about the expense allocation method used by the company in its illustrations and disclosed as required in subdivision (6) of subsection (c) of this section.

(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.

(Adopted effective January 1, 1999)

Sec. 38a-819-67. Reserved for future use

Sec. 38a-819-68. Separability

If any provision of sections 38a-819-58 to 38a-819-69, inclusive, of the regulations of Connecticut State Agencies or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of these regulations, and the application of such provision to other persons or circumstances, shall not be affected.

(Adopted effective January 1, 1999)

Sec. 38a-819-69. Effective date

Sections 38a-819-58 to 38a-819-69, inclusive, of the regulations of Connecticut State Agencies shall become effective January 1, 1999 and shall apply to policies sold on or after the effective date.

(Adopted effective January 1, 1999)

Military Sales Practices

Sec. 38a-819-70. Purpose

(a) The purpose of sections 38a-819-70 to 38a-819-75, inclusive, of the Regulations of Connecticut State Agencies is to set forth standards to protect service members of the United States Armed Forces from dishonest and predatory insurance sales practices by declaring certain identified practices to be false, misleading, deceptive or unfair.

(b) Nothing in sections 38a-819-70 to 38a-819-75, inclusive, of the Regulations of Connecticut State Agencies shall be construed to create or imply a private cause of action for a violation of sections 38a-819-70 to 38a-819-75, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective December 10, 2007)

Sec. 38a-819-71. Scope

Sections 38a-819-70 to 38a-819-75, inclusive, of the Regulations of Connecticut State Agencies shall apply to the solicitation or sale of any life insurance or annuity product by an insurer or insurance producer to an active duty service member of the United States Armed Forces.

(Adopted effective December 10, 2007)

Sec. 38a-819-72. Exemptions

Sections 38a-819-70 to 38a-819-75, inclusive, of the Regulations of Connecticut State Agencies shall not apply to solicitations or sales involving:

(1) Credit insurance;

(2) Group life insurance or group annuities where there is no in-person, face-to-face solicitation of individuals by an insurance producer or where the contract or certificate does not include a side fund;

(3) An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the Insurance Commissioner; or, when a term conversion privilege is exercised among corporate affiliates;

(4) Individual stand-alone health policies, including disability income policies;

(5) Contracts offered by Servicemembers' Group Life Insurance (SGLI) or Veterans' Group Life Insurance (VGLI), as authorized by 38 U.S.C. Section 1965 *et seq.*; or

(6) Life insurance contracts offered through or by a non-profit military association, qualifying under Section 501 (c)(23) of the Internal Revenue Code (IRC), and which are not underwritten by an insurer; or

(7) Contracts used to fund:

(A) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(B) A plan described by Sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the Internal Revenue Code (IRC), as amended, if established or maintained by an employer;

(C) A government or church plan defined in Section 414 of the Internal Revenue Code (IRC), a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the IRC;

(D) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(E) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(F) Prearranged funeral contracts.

(8) Nothing in sections 38a-819-70 to 38a-819-75, inclusive, of the Regulations of Connecticut State Agencies shall be construed to abrogate the ability of nonprofit organizations (or other organizations) to educate members of the United States Armed Forces in accordance with Department of Defense (DOD) Instruction 1344.07 – PERSONAL COMMERCIAL SOLICITATION ON DOD INSTALLATIONS OF SUCCESSOR directive.

(9) For purposes of sections 38a-819-70 to 38a-819-75, inclusive, of the Regulations of Connecticut State Agencies, general advertisements, direct mail and internet marketing shall not constitute solicitation. Telephone marketing shall not constitute solicitation provided the caller explicitly and conspicuously discloses that the product concerned is life insurance and makes no statements that avoid a clear and unequivocal statement that life insurance is the subject matter of the solicitation. Nothing in this subsection shall be construed to exempt an insurer or insurance producer from sections 38a-819-70 to 38a-819-75, inclusive, of the Regulations of Connecticut State Agencies in any in-person, face-to-face meeting established as a result of the solicitation exemptions identified in this subsection.

(Adopted effective December 10, 2007)

Sec. 38a-819-73. Definitions

As used in sections 38a-819-70 to 38a-819-75, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Active Duty" means full-time duty in the active military service of the United States and includes members of the reserve component (National Guard and Reserve) while serving under published orders for active duty or full-time training.

The term does not include members of the reserve component who are performing active duty or active duty for training under military calls or orders specifying periods of less than 31 calendar days.

(2) “Department of Defense (DOD) Personnel” means all active duty service members and all civilian employees, including nonappropriated fund employees and special government employees, of the Department of Defense.

(3) “Door to Door” means a solicitation or sales method whereby an insurance producer proceeds randomly or selectively from household to household without prior specific appointment.

(4) “General Advertisement” means an advertisement having as its sole purpose the promotion of the reader’s or viewer’s interest in the concept of insurance or in the promotion of the insurer or the insurance producer.

(5) “Insurer” means an insurance company required to be licensed under the laws of this state to provide life insurance products, including annuities.

(6) “Insurance producer” means a person required to be licensed under the laws of this state to sell, solicit or negotiate life insurance, including annuities.

(7) “Known” or “Knowingly” means, depending on its use in sections 38a-819-70 to 38a-819-75, inclusive, of the Regulations of Connecticut State Agencies, the insurance producer or insurer had actual awareness, or in the exercise of ordinary care should have known, that the person solicited is a service member.

(8) “Life Insurance” means insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income and unless otherwise specifically excluded, includes individually issued annuities.

(9) “Military Installation” means any federally owned, leased, or operated base, reservation, post, camp, building, or other facility to which service members are assigned for duty, including barracks, transient housing, and family quarters.

(10) “My Pay” means a Defense Finance and Accounting Service (DFAS) web-based system that enables service members to process certain discretionary pay transactions or provide updates to personal information data elements without using paper forms.

(11) “Service Member” means any active duty officer (commissioned and warrant) or enlisted member of the United States Armed Forces.

(12) “Side Fund” means a fund or reserve that is part of or otherwise attached to a life insurance policy (excluding individually issued annuities) by rider, endorsement or other mechanism which accumulates premium or deposits at interest or by other means. The term does not include (A) accumulated or cash value or secondary guarantees provided by a universal life policy; (B) cash values provided by a whole life policy which are subject to standard nonforfeiture law for life insurance; (C) or a premium deposit fund which (i) contains only premiums paid in advance which accumulate at interest; (ii) imposes no penalty for withdrawal; (iii) does not permit funding beyond future required premiums; (iv) is not marketed or intended as an investment; and (v) does not carry a commission, either paid or calculated.

(13) “Specific Appointment” means a prearranged appointment agreed upon by both parties and definite as to place and time.

(14) “United States Armed Forces” means all components of the Army, Navy, Air Force, Marine Corps, and Coast Guard.

(Adopted effective December 10, 2007)

Sec. 38a-819-74. Practices declared false, misleading, deceptive or unfair

(a) The following acts or practices when committed on a military installation by an insurer or insurance producer with respect to the in-person, face-to-face solicitation of life insurance are declared to be false, misleading, deceptive or unfair:

(1) Knowingly soliciting the purchase of any life insurance product “door to door” or without first establishing a specific appointment for each meeting with the prospective purchaser;

(2) Soliciting service members in a group or “mass” audience or in a “captive” audience where attendance is not voluntary;

(3) Knowingly making appointments with or soliciting service members during their normally scheduled duty hours;

(4) Making appointments with or soliciting service members in barracks, day rooms, unit areas, or transient personnel housing or other areas where the installation commander has prohibited solicitation;

(5) Soliciting the sale of insurance without first obtaining permission from an office designated by the installation commander;

(6) Posting unauthorized bulletins, notices or advertisements;

(7) Failing to present DD Form 2885, *Personal Commercial Solicitation Evaluation*, to service members solicited or encouraging persons solicited not to complete or submit a DD Form 2885; or

(8) Knowingly accepting an application for life insurance or issuing a policy of life insurance on the life of an enlisted member of the United States Armed Forces without first obtaining for the insurer’s files a completed copy of any required form which confirms that the applicant has received counseling or fulfilled any other similar requirement for the sale of life insurance established by regulations, directives or rules of DOD or any branch of the Armed Forces.

(b) The following acts or practices when committed on a military installation by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive or unfair:

(1) Using DOD personnel, directly or indirectly, as a representative or agent in any official or business capacity with or without compensation with respect to the solicitation or sale of life insurance to service members; or

(2) Using an insurance producer to participate in any United States Armed Forces sponsored education or orientation program.

(c) The following acts or practices by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive or unfair regardless of location:

(1) Submitting, processing or assisting in the submission or processing of any allotment form or similar device used by the United States Armed Forces to direct a service member’s pay to a third party for the purchase of life insurance. The foregoing includes, but is not limited to, using or assisting in using a service member’s MyPay account or other similar internet or electronic medium for such purposes. This subsection does not prohibit assisting a service member by providing insurer or premium information necessary to complete any allotment form;

(2) Knowingly receiving funds from a service member for the payment of premium from a depository institution with which the service member has no formal banking relationship. For purposes of this section, a formal banking relationship is established when the depository institution: (A) provides the service member a deposit agreement and periodic statements and makes disclosures required by the Truth in Savings Act, 12 USC § 4301 et seq. and the regulations promulgated thereunder; and (B)

permits the service member to make deposits and withdrawals unrelated to the payment or processing of insurance premiums;

(3) Employing any device or method or entering into any agreement whereby funds received from a service member by allotment for the payment of insurance premiums are identified on the service member's Leave and Earnings Statement or equivalent or successor form as "Savings" or "Checking" and where the service member has no formal banking relationship as defined in subdivision (2) of this subsection;

(4) Entering into any agreement with a depository institution for the purpose of receiving funds from a service member whereby the depository institution, with or without compensation, agrees to accept direct deposits from a service member with whom it has no formal banking relationship;

(5) Using DOD personnel, directly or indirectly, as a representative or agent in any official or unofficial capacity with or without compensation with respect to the solicitation or sale of life insurance to service members who are junior in rank or grade, or to the family members of such personnel;

(6) Offering or giving anything of value, directly or indirectly, to DOD personnel to procure their assistance in encouraging, assisting or facilitating the solicitation or sale of life insurance to another service member;

(7) Knowingly offering or giving anything of value to a service member with a pay grade of E-4 or below for his or her attendance to any event where an application for life insurance is solicited; or

(8) Advising a service member with a pay grade of E-4 or below to change his or her income tax withholding or State of legal residence for the sole purpose of increasing disposable income to purchase life insurance.

(d) The following acts or practices by an insurer or insurance producer lead to confusion regarding source, sponsorship, approval or affiliation and are declared to be false, misleading, deceptive or unfair:

(1) Making any representation, or using any device, title, descriptive name or identifier that has the tendency or capacity to confuse or mislead a service member into believing that the insurer, insurance producer or product offered is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. Government, the United States Armed Forces, or any State or Federal agency or government entity. Examples of prohibited insurance producer titles include, but are not limited to, "Battalion Insurance Counselor," "Unit Insurance Advisor," "Servicemen's Group Life Insurance Conversion Consultant," or "Veteran's Benefits Counselor." Nothing in sections 38a-819-70 to 38a-819-75, inclusive, of the Regulations of Connecticut State Agencies shall be construed to prohibit a person from using a professional designation awarded after successful completion of a course of instruction in the business of insurance by an accredited institution of higher learning. Such designations include, but are not limited to, Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC), Certified Financial Planner (CFP), Master of Science In Financial Services (MSFS), or Masters of Science Financial Planning (MS); or

(2) Soliciting the purchase of any life insurance product through the use of or in conjunction with any third party service or fraternal organization that promotes the welfare of or assists members of the United States Armed Forces in a manner that has the tendency or capacity to confuse or mislead a service member into believing that either the insurer, insurance producer or insurance product is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. Government, or the United States Armed Forces.

(e) The following acts or practices by an insurer or insurance producer lead to confusion regarding premiums, costs or investment returns and are declared to be false, misleading, deceptive or unfair:

(1) Using or describing the credited interest rate on a life insurance policy in a manner that implies that the credited interest rate is a net return on premium paid; or

(2) Excluding individually issued annuities, misrepresenting the mortality costs of a life insurance product, including stating or implying that the product “costs nothing” or is “free”.

(f) The following acts or practices by an insurer or insurance producer regarding SGLI or VGLI are declared to be false, misleading, deceptive or unfair:

(1) Making any representation regarding the availability, suitability amount, cost, exclusions or limitations to coverage provided to a service member or dependents by SGLI or VGLI, which is false, misleading or deceptive;

(2) Making any representation regarding conversion requirements, including the costs of coverage, or exclusions or limitations to coverage of SGLI or VGLI to private insurers which is false, misleading or deceptive; or

(3) Suggesting, recommending or encouraging a service member to cancel or terminate his or her SGLI policy or issuing a life insurance policy which replaces an existing SGLI policy unless the replacement shall take effect upon or after the service member’s separation from the United States Armed Forces.

(g) The following acts or practices by an insurer or insurance producer regarding disclosure are declared to be false, misleading, deceptive or unfair:

(1) Deploying, using or contracting for any lead generating materials designed exclusively for use with service members that do not clearly and conspicuously disclose that the recipient will be contacted by an insurance producer, if that is the case, for the purpose of soliciting the purchase of life insurance;

(2) Failing to disclose that a solicitation for the sale of life insurance will be made when establishing a specific appointment for an in-person face to face meeting with a prospective purchaser;

(3) Excluding individually issued annuities, failing to clearly and conspicuously disclose the fact that the product being sold is life insurance;

(4) Failing to make, at the time of sale or offer to an individual known to be a service member, the written disclosures required by Section 10 of the “Military Personnel Financial Services Protection Act,” Pub. L. No. 109-290, p.16; or

(5) Excluding individually issued annuities, when the sale is conducted in-person face-to-face with an individual known to be a service member, failing to provide the applicant at the time the application is taken: (A) an explanation of any free look period with instructions on how to cancel if a policy is issued; and (B) either a copy of the application or a written disclosure. The copy of the application or the written disclosure shall clearly and concisely set out the type of life insurance, the death benefit applied for and its expected first year cost. A basic illustration that meets the requirements of section 38a-819-62 shall be deemed sufficient to meet this requirement for a written disclosure.

(h) The following acts or practices by an insurer or insurance producer with respect to the sale of certain life insurance products are declared to be false, misleading, deceptive or unfair:

(1) Excluding individually issued annuities, recommending the purchase of any life insurance product which includes a side fund to a service member in pay grades E-4 and below unless the insurer has reasonable grounds for believing that the life insurance death benefit, standing alone, is suitable;

(2) Offering for sale or selling a life insurance product which includes a side fund to a service member in pay grades E-4 and below who is currently enrolled in SGLI, is presumed unsuitable unless, after the completion of a needs assessment, the insurer demonstrates that the applicant's SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicant's insurable needs for life insurance. (A) Insurable needs are the risks associated with premature death taking into consideration the financial obligations and immediate and future cash needs of the applicant's estate and survivors or dependents. (B) Other military survivor benefits include, but are not limited to: the Death Gratuity, Funeral Reimbursement, Transition Assistance, Survivor and Dependents' Educational Assistance, Dependency and Indemnity Compensation, TRICARE Healthcare Benefits, Survivor Housing Benefits and Allowances, Federal Income Tax Forgiveness, and Social Security Survivor Benefits;

(3) Excluding individually issued annuities, offering for sale or selling any life insurance contract which includes a side fund: (A) unless interest credited accrues from the date of deposit to the date of withdrawal and permits withdrawals without limit or penalty; (B) unless the applicant has been provided with a schedule of effective rates of return based upon cash flows of the combined product. For this disclosure, the effective rate of return will consider all premiums and cash contributions made by the policyholder and all cash accumulations and cash surrender values available to the policyholder in addition to life insurance coverage. This schedule will be provided for at least each policy year from one (1) to ten (10) and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and (C) which by default diverts or transfers funds accumulated in the side fund to pay, reduce or offset any premiums due;

(4) Excluding individually issued annuities, offering for sale or selling any life insurance contract which after considering all policy benefits, including but not limited to endowment, return of premium or persistency, does not comply with standard nonforfeiture law for life insurance; or

(5) Selling any life insurance product to an individual known to be a service member that excludes coverage if the insured's death is related to war, declared or undeclared, or any act related to military service except for an accidental death coverage such as double indemnity, which may be excluded.

(Adopted effective December 10, 2007)

Sec. 38a-819-75. Severability

If any provision of sections 38a-819-70 to 38a-819-74, inclusive, of the Regulations of Connecticut State Agencies or the application thereof to any person or circumstance is held invalid for any reason, the invalidity shall not affect the other provisions or any other application of these sections which can be given effect without the invalid provisions or application. To this end all provisions of said sections are declared to be severable.

(Adopted effective December 10, 2007)

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Regulations Governing the Availability of Insurance on Real Property Regardless of Location

Sec. 38a-824-1. Purpose

The purpose of this regulation is to ensure the availability of insurance on real property in the State of Connecticut by prohibiting unfair discrimination in the availability or sale of such insurance on the basis of location, age or disparity between replacement cost and market value of such property.

(Effective September 25, 1992)

Sec. 38a-824-2. Applicability

This regulation shall apply to every insurer licensed to write insurance on residential property in the State of Connecticut, as well as any officers, representatives, agents or employees of such insurers. As used herein "insurance" means fire insurance or homeowners insurance on owner-occupied buildings with four or fewer dwelling units, or on individual residences, including apartment unit, rooms, and houses, occupied by the applicant or the named insured.

(Effective September 25, 1992)

Sec. 38a-824-3. Acts constituting unfair discrimination

(a) Except as provided in subsection (b) of this section, the following acts, practices or methods if committed with such frequency as to indicate a general practice shall be deemed to constitute unfair discrimination.

(1) Refusing to issue homeowners policies solely because of the fact that the risk is located in a particular urban area or neighborhood, city or town.

(2) Requiring homeowners insurance policies to be purchased in amounts above 80% of replacement cost value.

(3) Limiting the sale of homeowners insurance policies to 80% of replacement cost value without offering homeowners insurance policies which provide coverage in amounts not less than the greater of the market value of the property or 50% of the replacement cost value, in accordance with rating plans filed with the Commissioner.

(4) Refusing to insure dwellings solely because of a substantial disparity between replacement cost and market value.

(5) Refusing to issue, refusing to renew, cancelling or limiting the amount or provisions of coverage solely because of the age of structure.

(6) Refusing to issue, refusing to renew, cancelling or limiting the amount or provisions of coverage due to the condition of adjacent or nearby properties unless there are objectively identifiable hazards associated with such properties which significantly increase the risk.

(7) Varying the application of any or all of the following standards or practices by geographic locations of the risk by:

(A) Use of previous denial of coverage or termination by another insurer;

(B) Use of insurance application information concerning whether the applicant was previously denied coverage or was terminated by another insurer;

(C) Use of previous coverage under an involuntary insurance plan;

(D) Use of insurance information concerning whether the applicant was previously covered in an involuntary insurance plan;

(E) Providing a statement to applicants and insureds regarding the reasons for insurer's declination, termination, or nonrenewal of an insurance contract;

(F) Providing a statement to applicants and insureds before issuing notices of declination, termination, or non-renewal regarding corrective action, if any, the applicant or insured must take to obtain or continue coverage;

(G) Use of deductibles.

This subdivision (7) shall not prohibit the use of any standard or practice merely because it affects various areas differently, provided such standard or practice is applied uniformly in all geographic locations.

(b) Subdivisions (2), (3), (4) and (5) of Subsection (a) shall not be applicable to an insurer when one or more insurers in the insurer group actively offers policies which meet the requirements of such subdivision.

(Effective September 25, 1992)