New Rule, R.1998 d.302, effective June 15, 1998.
See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).

SUBCHAPTERS 38 THROUGH 39. (RESERVED)

SUBCHAPTER 40. LIFE/HEALTH/ANNUITY FORMS

11:4–40.1 Purpose and scope

(a) The purpose of this subchapter is to implement P.L. 1995, c.73 (the Life and Health Insurance and Health Maintenance Organization Form Approval Reform Act) by setting forth standards and procedures whereby all life insurance, health insurance, and annuity forms, and rates where applicable, are to be submitted to the Commissioner for his or her approval prior to use. This subchapter also establishes a file and use system for certain forms deemed eligible by the Commissioner provided that a certification is filed that the particular form complies with the law and rules applicable to it.

(b) This subchapter shall apply to all life insurance, health insurance and annuity forms issued pursuant to N.J.S.A. 17B:17–1 et seq.; all hospital service corporation contracts issued pursuant to N.J.S.A. 17:48–1 et seq.; all medical service corporation contracts issued pursuant to N.J.S.A. 17:48A–1 et seq.; all health service corporation contracts issued pursuant to N.J.S.A. 17:48E–1 et seq.; and all health maintenance organization contracts, evidence of coverage and related forms issued pursuant to N.J.S.A. 26:2J–1 et seq. This subchapter shall not apply to any forms issued pursuant to N.J.S.A. 17B:27A–2 et seq. or 17B:27A–17 et seq., but shall apply to all forms issued pursuant to N.J.S.A. 17B:27A–7 and N.J.S.A. 17B:27A–19.

11:4–40.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Annuity" means a contract not included within the definitions of life insurance or health insurance as set forth in this section, under which an insurer obligates itself to make periodic payments for a specified period of time, such as for a number of years, or until the happening of an event, or for life or for a period of time determined by any combination thereof. A contract which includes extra benefits of the kinds set forth in the definitions of life insurance or health insurance set forth in this section shall nevertheless be deemed to be an annuity if such extra benefits constitute a subsidiary or incidental part of the entire contract.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Contract on a variable basis" or "variable contract" means any separate account contract providing for the dollar amount of life insurance or annuity benefits or other contractual payments or values thereunder to vary so as to reflect investment results of one or more separate accounts in which amounts with respect to any such contracts shall have been placed.

"Department" means the New Jersey Department of Banking and Insurance.

"Form" or "policy form" or "life/health/annuity form or contract" means any individual or group policy form or contract providing life insurance, health insurance or annuity benefits; any application for such a policy, contract or certificate if a written application is required and is to be made part of that policy or contract; any rider or endorsement for use with such a policy or contract; certificates of such insurance; any evidence of such insurability form; any health maintenance organization contract; and any evidence of such coverage or related form delivered or issued for delivery in this State.

"Funeral insurance policy" means a policy as defined at N.J.S.A. 17B:17–5.1.

"Health insurance" means a contract or agreement whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the bodily injury, disablement, sickness, death by accident or accidental means of a human being, or because of any expense relating thereto, or because of any expense incurred in prevention of sickness, and includes every risk pertaining to any of the enumerated risks. Health insurance does not include workers' compensation coverage or stop-loss coverage.

"Insurer" means a hospital service corporation operating pursuant to N.J.S.A. 17:48–1 et seq.; a medical service corporation operating pursuant to N.J.S.A. 17:48A–1 et seq.; a health service corporation operating pursuant to N.J.S.A. 17:48E–1 et seq.; a life, health or annuity company operating pursuant to N.J.S.A. 17B:17–1 et seq.; and a fraternal benefit society operating pursuant to N.J.S.A. 17:44A–1 et seq. to the extent that it issues certificates or evidence of coverage forms containing accident or health benefits. A fraternal benefit society that issues certificates containing life insurance benefits is not considered an insurer for purposes of this subchapter.

"Life insurance" means a policy or contract whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the cessation of human life. Life insurance also includes the granting of endowment benefits and optional modes of settlement of proceeds of life insurance, as well as provisions for additional benefits in the event of death by accident or accidental means or in the

event of dismemberment or loss of sight; or safeguarding such insurance against lapse or giving a special surrender value, or special benefit or annuity in the event that the insured shall become totally and permanently disabled, whether such provisions are incorporated in a policy or contract of life insurance or in a policy or contract supplemental thereto. Life insurance does not include worker's compensation coverage.

"Limited death benefit policy" means a policy as defined at N.J.A.C. 11:4–21.

"Published guidelines" means guidelines published by the Commissioner on or before April 10, 1995.

"Responsible officer of the insurer" means a corporate officer of the level of vice president or higher, or of an equivalent title within the insurer's corporate structure, who is either an actuary of the insurer with responsibility for the type of form filed, or the individual with responsibility for managing the form filing process for the insurer with regard to the type of form filed.

"Separate account" means any segregated portfolio of investment or designated account of an insurer established pursuant to N.J.S.A. 17B:28–1 et seq.

"State" means the State of New Jersey.

"Stop loss or excess risk insurance" means insurance designed to reimburse a self-funded arrangement for catastrophic and unexpected expenses exceeding specified per person retention limits of no less than $25,000 per year and/or aggregate retention limits of no less than 125 percent of expected claims per year, wherein neither the employees nor other individuals are third party beneficiaries under the policy, contract or plan.

"Universal flexible-factor form" means any life insurance policy, rider or endorsement, whether participating or nonparticipating, which permits the insurer to reserve the right to modify (upward or downward) premiums, premium factors (interests, mortality, expenses), or benefits (death benefits, cash or loan values) on the basis of future anticipated or emerging experience.

Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

11:4–40.3 Life/health/annuity form approval standards

(a) All life, health and annuity forms shall comply with the standards set forth in this subchapter and in any other applicable statutes, rules and published guidelines before being delivered or issued for delivery in this State.

(b) No form delivered or issued for delivery in this State shall contain provisions which are unjust, unfair, inequitable, misleading or contrary to law or to the public policy of this State.

11:4–40.4 General requirements

(a) All insurers submitting forms or other correspondence to the Department pursuant to this subchapter shall comply with the following general procedures:

1. All individual health, group health, blanket, prepaid legal contracts, group life and service corporation forms and other related correspondence submitted or resubmitted for approval or for file and use pursuant to this subchapter shall be submitted to the Department at the following address:

New Jersey Department of Banking and Insurance
Health Bureau
20 West State Street
PO Box 470
Trenton, NJ 08625–0470

2. All individual life, credit life and health, mortgage guaranty, separate account, variable contract and annuity forms and other related correspondence pursuant to this subchapter submitted or resubmitted for approval or for file and use shall be submitted to the Department at the following address:

New Jersey Department of Banking and Insurance
Life Bureau
20 West State Street
PO Box 470
Trenton, NJ 08625–0470

3. All submissions and resubmissions of forms to the Department shall include a self-addressed, stamped envelope.

4. For purposes of computing time limits in this subchapter, "days" shall mean calendar days, except that when the last day of any specified time period is a Saturday, Sunday or State holiday, then the time period shall end on the next following business day. With regard to any specified time period relating to documents or correspondence transmitted between the Department and the insurer, the Department shall rely on one of the following:

i. The date appearing on a clear, legible postmark affixed by the United States Postal Service;

ii. The legible date of receipt from the sender appearing on the transmission documents of a private delivery service; or

iii. In the absence of either (a)4i or ii above, the actual date of receipt by the Department.

Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

11:4–40.5 Life/health/annuity form approval procedures

(a) No insurer shall deliver or issue for delivery in this State any form unless the form has been approved by the Commissioner pursuant to the procedures set forth in this subchapter, except for those forms eligible for submission to the Commissioner pursuant to the file and use system described in this subchapter at N.J.A.C. 11:4–40.8 and 40.9.

(b) An insurer seeking approval of a form shall submit a complete form filing to the Department, which shall include the items set forth below:

1. A properly completed Initial Submission Data Form as set forth at Exhibit A in the Appendix to this subchapter, incorporated herein by reference;

2. A specimen copy of the form in duplicate;

3. A cover letter in duplicate, which shall include the following:

i. The insurer's identity;

ii. The form number(s) of the form(s) being submitted. If several forms are being submitted, the form numbers may be included as an attachment to the cover letter;

iii. A general description of the nature of the form(s), including, but not limited to, the specific market and issue ages;

iv. The identity of one individual authorized as the insurer's contact person for the form(s) being filed;

v. A statement as to whether the form was previously submitted to the Department, including the date and status of any such submission; and

vi. For rider forms or endorsements, an explanation of the manner in which the rider or endorsement affects the mortality basis or premiums for the base policy;

4. A certification signed by a responsible officer of the insurer that the forms comply with all laws, rules, bulletins and published guidelines applicable to the particular type of form. The certification may be included in the text of the cover letter described in (b)3 above if the cover letter is signed by a responsible officer of the insurer;

5. A readability certification if required pursuant to N.J.S.A. 17B:17–21d;

6. An actuarial memorandum which complies with the requirements of any applicable statutes, rules or published guidelines, and premium rates if required by this subchapter or other law or rule, for the particular type of form being submitted;

7. The appropriate service fee set forth at N.J.A.C. 11:1–32 if required;

8. Any additional items required to be submitted for forms as specifically set forth at other sections of this subchapter; and

9. Where the form submitted is a rider, endorsement, insert page or supplemental form, a listing of the policy form number(s) and approval date(s) of the policy form(s) with which the form submitted is to be used and a specimen copy of an approved policy form.

(c) The Department shall, within 25 days of receipt, return an incomplete filing to the insurer with a notice indicating that the filing is being returned with no action by the Department, and that time for the Department's substantive review for approval of the form and/or rate filing has not commenced.

(d) A form/rate filing shall be deemed approved upon the expiration of 60 days following submission of the filing to the Commissioner unless the Department approves or disapproves the filing in writing within that 60–day period. If approval is deemed, the insurer shall notify the Department in writing prior to use of its intent to use the form.

1. The Department's written disapproval of a filing shall include the following:

i. The specific reasons for the disapproval, which shall be limited to only the standards set forth in this subchapter at N.J.A.C. 11:4–40.3, and in any laws, rules, bulletins or published guidelines applicable to the particular type of form being disapproved; and

ii. A Resubmission Data Form for use by the insurer in resubmitting the disapproved filing.

2. A form filing which is disapproved by the Department prior to the expiration of the 60–day disapproval period shall be deemed withdrawn at the expiration of the 60–day period following notice of disapproval unless the insurer resubmits the disapproved form filing within the 60–day period pursuant to the procedures set forth in (e) below.

(e) An insurer may resubmit a form filing which has been disapproved by the Commissioner pursuant to (d) above. The resubmission shall include the items set forth below:

1. A properly completed Resubmission Data Form;

2. A cover letter in duplicate, which shall include all the information required to be included in the initial submission cover letter as set forth at (b) above, in addition to the Department submission number;

3. The revised form(s) or page(s) only, if practicable, of the disapproved form(s). One copy shall be marked to show the changes from the prior submission, and one copy shall be unmarked. The resubmission shall also include a marked copy of any revised support material (for example, a periodic report);

4. A certification signed by a responsible officer of the insurer that the resubmission is the same as the original form filing, with the exception of the item(s) identified as modified or new; and

5. The resubmission shall completely respond to all the objections raised in the Department's disapproval of the initial or previous submission; otherwise, the Department shall return the resubmission as incomplete.

(f) A complete form filing resubmission shall be deemed approved upon the expiration of 30 days following resubmission of the filing to the Commissioner unless the Department approves or disapproves the resubmission in writing within that 30–day period. If approval is deemed, the insurer shall notify the Department in writing prior to use of its intent to use the form.

1. The Department's written disapproval of a form filing resubmission shall include the specific reasons for disapproval of the resubmission, which shall be limited to only the objections specifically stated in the Department's initial disapproval of the form filing except to the extent that the resubmission contains new provisions not included in the initially disapproved form filing or any changes or modifications to any substantive provisions of the form filing.

(g) If the Department issues a written disapproval of a resubmitted form filing prior to the expiration of the 30–day disapproval period, the filing shall be deemed withdrawn at the expiration of the 30–day period following disapproval unless the insurer resubmits a disapproved form filing within the 30–day period pursuant to the procedures set forth in this subsection.

11:4–40.6 Individual life and annuities variable form approval procedures

(a) In addition to those items set forth at N.J.A.C. 11:4–40.5, insurers seeking approval of individual life and annuities variable forms shall include, if applicable, the following items in the submission to the Department:

1. A prospectus; and

2. An actuarial memorandum which discusses the derivation of cash values and all current and maximum charges deducted in determining the separate account values.

Amended by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
In (a), deleted former 3.

11:4–40.7 Valuation and non-forfeiture interest rates form approval procedures

(a) In addition to those items set forth at N.J.A.C. 11:4–40.5, insurers seeking approval of valuation and non-forfeiture interest rate changes to previously filed forms shall include, if applicable, the following items in the submission to the Department:

1. If the interest rate and/or non-forfeiture values appearing on the form change as a result of the new interest rate, the submission shall include the new page(s) bearing distinct identifying form numbers for filing;

2. A revised actuarial memorandum reflecting the change in interest rate or a statement that the new rate does not affect the memorandum currently on file;

3. Pursuant to N.J.S.A. 17B:25–19h(x), an insurer is not required to refile other provisions of the form to file the changes described in (a)1 and 2 above; and

4. The interest rate and non-forfeiture values may be filed as variable to the extent they are equal to or determinable from the maximum interest rate, and cash values calculated using that rate, as described in N.J.S.A. 17B:25–19. Insurers shall place variable brackets around the appropriate item(s) on the revised policy page(s).

(b) The Department shall acknowledge a submission indicating a change in the valuation interest rate and amending actuarial data related to reserve calculations. If a form actually refers to, or contains provisions depending on, the valuation interest rate, the submission shall be treated as a refiling of policy pages to change the interest rate pursuant to (a)1 and 2 above.

11:4–40.8 Certificate of assumption form approval procedures

(a) In addition to those items set forth at N.J.A.C. 11:4–40.5, insurers seeking approval of certificates of assumption shall include, if applicable, the following items in the submission to the Department:

1. A clear indication whether the assuming and ceding insurers are authorized in this State for the lines of business being assumed;

2. A general description of the type of business being assumed;

3. A list of the forms and filing dates with which the certificate will be used, together with a copy of the Department's filing letters applicable to these forms;

4. For forms intended for use with group business, the provisions of the form must be consistent with both the group contract and certificate form;

5. Evidence of approval of both the transaction and the forms, if required, by the state of domicile of the assuming and ceding insurers;

6. All communications between either the assuming or ceding insurer with the policyholders, including letters, memoranda, identification cards, advertisements or other material;

7. Affirmative consent of the owner is not required, but if obtained, the consent form shall be part of the submission. The certificate of assumption form shall not include a provision indicating that consent of the policyholder is deemed or implied as the result of some positive or negative action;

8. A certification by the assuming insurer that it will adhere to all conditions and representations which were part of the original filing of the forms being assumed;

9. Certifications by the assuming and ceding insurers that any communications by a policyholder with the ceding insurer will have the same legal status as a communication which is sent directly to the assuming insurer. Additionally, the ceding insurer shall certify that it will maintain systems to forward all communications of this nature to the assuming insurer;

10. The certificate of assumption form shall include the following:

i. An appropriate title, such as Certificate of Assumption;

ii. The business address of both the ceding and assuming insurers;

iii. Clear directions regarding the submission of payments and claims; and

iv. The signature of an officer of the insurer, and a statement that the form is to be attached to and made part of the policy; and

11. If health insurance or credit insurance is being assumed, the assuming insurer shall agree that rate revisions will be based on the experience since the original issue date. It is the responsibility of the assuming insurer to obtain and maintain the necessary experience data.

11:4–40.9 File and use eligibility

(a) An insurer may deliver or issue for delivery in this State a form providing life, health or annuity benefits, and accompanying rates if applicable, without obtaining prior approval from the Commissioner pursuant to this subchapter provided the form is set forth in this section as a type eligible for file and use and is filed with the Commissioner pursuant to the procedures set forth at N.J.A.C. 11:4–40.10.

(b) The following types of non-variable individual life insurance forms shall be eligible for file and use pursuant to this section:

1. Scheduled premium term policies without cash values, other than universal/flexible-factor forms, multiple-life forms with survivorship benefits, limited death benefit forms, policies with re-entry options, single premium forms, field issued forms or funeral insurance;

2. Accidental death benefit;

3. Business exchange/substitute insured;

4. Cost of living benefit;

5. Option to purchase additional insurance;

6. Waiver of premium;

7. Spouse and/or child rider;

8. Individual retirement account (IRA) endorsement; and

9. Applications.

(c) The following types of non-variable individual annuity forms shall be eligible for file and use pursuant to this section:

1. Immediate annuities, other than structured settlement, field issued forms or funeral insurance;

2. Scheduled premium deferred annuities, other than structured settlement, field issued forms or funeral insurance;

3. Flexible premium deferred annuities, other than structured settlement, field issued forms or funeral insurance;

4. Individual retirement account (IRA) endorsement;

5. Waiver of premium; and

6. Applications.

(d) The following types of individual health insurance forms shall be eligible for file and use pursuant to this section:

1. Business buyout, keyperson and overhead expense disability income policies;

2. Medical expense conversion policies in which a portion of the premium is chargeable to or subsidized by the group policy from which conversion is made;

3. Benefit riders for use with the type of policies set forth at (d)1 and 2 above; and

4. Applications other than those used with medicare supplement and long-term care policies.

(e) The following types of non-variable group life insurance forms shall be eligible for file and use pursuant to this section:

1. Policies and certificate forms which provide life insurance benefits only, and which do not provide cash values or loan values other than funeral expense;

2. Retired lives reserve contracts;

3. Benefit riders for use with the type of policies set forth at (e)1 and 2 above; and

4. Applications and evidence of coverage forms.

(f) The following types of group health insurance forms shall be eligible for file and use pursuant to this section:

1. Policies, certificates and evidence of coverage which provide only temporary disability benefits pursuant to N.J.S.A. 34:15–1 et seq.;

2. Policies and certificates which provide only disability income benefits for loss due to both accident and sickness and which are sold exclusively to employer groups;

3. Benefit riders for use with the type of policies set forth at (f)1 and 2 above; and

4. Applications and evidence of coverage forms.

(g) The following types of group annuities forms shall be eligible for file and use pursuant to this section:

1. Contracts;

2. Certificate forms; and

3. Applications.

(h) In the month of September or October of each year, the Department shall conduct a hearing pursuant to P.L. 1995, c.73 for the purpose of determining the specific types of forms eligible for file and use pursuant to this section.

1. The hearing shall be preceded by a notice of hearing published in the New Jersey Register at least 30 days prior to the date of the hearing, which notice shall include information concerning the date by which, and the person to whom, written public comment may be made. Notice shall also be provided to persons who have previously requested receipt of such notice.

2. The notice published in the New Jersey Register and as otherwise provided pursuant to (h)1 above shall also request that persons who wish to testify at the hearing provide the Department with timely notice of this intention, including a brief summary of the subject matter of their testimony.

3. The notice shall indicate whether the hearing shall address the merits of maintaining all forms currently on the file and use eligibility list, or whether the hearing will consider only specific additions, deletions or clarifications regarding the list.

4. The hearing shall be conducted by a hearing officer designated by the Commissioner. The length of testimony permitted at the hearing and the receipt of questions from the floor will be within the discretion of the hearing officer.

5. A transcript of the hearing shall be made and a copy thereof shall be made available to any interested person upon request and payment of the appropriate fee.

6. The record of the hearing shall include the following:

i. Timely-received written public comments;

ii. The transcript of the hearing; and

iii. Any other information which the hearing officer may deem relevant.

7. The record and transcript of the hearing shall be public records pursuant to N.J.S.A. 47:1A–1 et seq. except to the extent that any information is submitted pursuant to a statute or rule providing for confidentiality.

8. Upon review of the file and use eligibility list hearing record, the Commissioner shall determine within 30 days whether any modifications should be made by rule to the current list.

9. If the Commissioner determines during the term of a duly promulgated file and use eligibility list that changed conditions require a modification of the list, the Commissioner may amend the list by rule following a hearing conducted pursuant to this subsection.

Public Notice: Hearing to determine forms eligible for filing and use.
See: 28 N.J.R. 4121(a).
Public Notice: Hearing to determine forms eligible for filing and use.
See: 30 N.J.R. 3108(b).
Public Notice: Hearing to determine forms eligible for filing and use.
See: 33 N.J.R. 3379(a).

11:4–40.10 File and use procedures

(a) An insurer seeking to file and use a form specified at N.J.A.C. 11:4–40.9 to be eligible for file and use shall, in addition to the items set forth at N.J.A.C. 11:4–40.5(b), submit the following to the Department:

1. A certification memorandum signed and acknowledged by a responsible officer of the insurer, which shall include the following:

i. A statement that the certification is filed pursuant to P.L. 1995, c.73, section 17;

ii. A statement that the responsible officer signing the certification memorandum is authorized to execute the document;

iii. A statement that the responsible officer signing the certification memorandum is familiar with the insurer's filing and all laws, regulations, bulletins and published guidelines applicable to the particular type of form, and that the form complies with all laws, regulations, bulletins and published guidelines applicable to the particular type of form;

iv. A statement that the insurer intends for the Department to rely on the certification in accepting the filing made pursuant to this subsection;

v. A statement that the responsible officer signing the certification memorandum is aware of the penalties for submitting an improper certification or false filing;

vi. A statement that the responsible officer signing the certification memorandum has supervised and is responsible for the completion and submission to the Department of the checklist required for the particular type of form; and

vii. A statement that the insurer shall not use the form before receipt of the form is acknowledged by the Department.

(b) The Department shall provide the insurer with a written acknowledgement that the Department received the form and a proper certification.

(c) Upon receipt of the written acknowledgment described in (b) above, the insurer may use the form in this State.

(d) If the Commissioner determines that the form submitted to the Department by the insurer pursuant to (a) above fails to comply with any law, or regulation, bulletin or published guideline applicable to the particular type of form, the Department shall notify the insurer in writing of the specific reasons for objecting to the form, and may disapprove the form for further use in this State.

(e) If the Commissioner determines that the certification submitted to the Department by the insurer pursuant to (a) above is an improper certification, the insurer shall be subject to the following penalties specifically determined by the Commissioner in consideration of the severity of the violation based on the potential adverse impact to the public and whether it is the insurer's first such violation:

1. A fine not to exceed $50,000; and

2. A maximum penalty of $1,000 per contract or certificate issued with a form determined to be improperly certified pursuant to this subsection.

i. For purposes of this subsection, an "improper certification" means a certification that provides any misrepresentation or false statement material to a certification form.

(f) If, following notice and a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, an insurer is found by the Commissioner to be in violation of any of the requirements of this section, the form may be disapproved and the insurer may be barred from participating in the certification process pursuant to this section for a period not to exceed one year. These penalties are in addition to any penalties that may be imposed pursuant to any other law or regulation applicable to the particular insurer for such violation(s).

11:4–40.11 Service fees

A form submitted by an insurer to the Commissioner for either prior approval or file and use pursuant to this subchapter shall be accompanied by the service fee(s) set forth at N.J.A.C. 11:1–32 unless the insurer is exempt from the payment of such fees pursuant to section 13 of P.L. 1995, c.156, enacted on June 30, 1995.

APPENDIX

EXHIBIT A

FOR DEPARTMENT OF INSURANCE
USE ONLY, DO NOT USE SHADED AREAS

PAGE: ___ OF ___

NEW JERSEY
DEPARTMENT OF INSURANCE
POLICYFORM REVIEW

**** NEW SUBMISSION ****

SUBMISSION NO.: ___ - _______ - ___

NAIC CODE: ______

COMPANY NAME: ______________________________

GROUP CODE (if any): ___

DATE SENT: ___ / ___ / ___

DATE RECEIVED: ___ / ___ / ___

SERVICE FEE submitted: _______ . ___ **(if applicable)**

CHECK NUMBER: __________

CHECK DATE: ___ / ___ / ___

CATEGORY OF FORMS: ___

NUMBER OF FORMS SUBMITTED: ___

POLICYFORM NUMBER	COVER. TYPE	FORM TYPE	REQ. TYPE	RATE CHANGE (%)
				.
				.
				.
				.
				.
				.
				.
				.
				.
				.
				.
				.

ATTACHMENT 1
INSTRUCTIONS FOR INITIAL SUBMISSION
DATA FORMS

The Initial Submission Data Form requires that you provide codes for the Category, Coverage Type, and Request Type. These codes are attached.

Submission No:

Leave Blank–For Department Use.

NAIC Code:

5 Digit NAIC Code. All companies are identified in the system by NAIC code rather than name.

Company Name:

GROUP HEALTH (SERVICE CORP.)

CODE	COVERAGE TYPE
U0	Group Medical Expense (Service Corp.)
U1	Group Medicare Supplement (Service Corp.)
U4	Group Long Term Care (Service Corp.)
U5	Group Dental (Service Corp.)
U6	Group Accident Only (Service Corp.)
U7	Group Blanket Insurance (Service Corp.)
U8	Group Student Coverage (Service Corp.)
U9	Group Stop Loss Coverage (Excess Coverage) (Service Corp.)
UZ	Other (Group Health Service Corp.)

Notes: Use the form number on the face page of a policy or certificate when type of form is PP or CC (A complete policy or certificate). (Complete Applications, Endorsements, and Riders with multiple pages can be coded the same way.)

When the submission contains multiple insert pages (not a complete policy or certificate) only the first form number should be coded followed by the suffix et al. Use the Form Type CI or PI.

INDIVIDUAL CREDIT

CODE	COVERAGE TYPE
90	Credit Life—Single Premium
91	Credit Health—Single Premium
92	Credit Life—MOB
93	Credit Health—MOB
94	Credit L & H—Truncated Coverage
95	Credit L & H—Leases
96	Mortgage Life
97	Mortgage Health
98	Other Credit (Riders & Endorsements)
99	Critical Period Coverage (Individual Credit)
9Y	Combination of Coverage (Individual Credit)

GROUP CREDIT

CODE	COVERAGE TYPE
9A	Credit Life—Single Premium (Group)
9B	Credit Health—Single Premium (Group)
9C	Credit Life—MOB (Group)
9D	Credit Health—MOB (Group)
9E	Credit L & H—Truncated Coverage (Group)
9F	Credit L & H—Leases (Group)
9G	Mortgage Life (Group)
9H	Mortgage Health (Group)
9I	Other Credit (Riders & Endorsements) (Group)
9J	Critical Period Coverage (Group Credit)
9K	Combination of Coverage (Group Credit)

MORTGAGE GUARANTEE

CODE	COVERAGE TYPE
MG	Mortgage Guarantee

Notes: Use codes other than 98 or 9I to classify policies, certificates, and notices which apply to a particular sort of insurance.

Use codes 98 and 9I for forms that apply to all sorts of coverage (i.e., certificates of assumption).

Combination of Coverage code is used when a rider, endorsement or application are intended for use with more than one Coverage Type.

SUBCHAPTER 41. STANDARDS FOR INDIVIDUAL LIFE INSURANCE POLICY FORMS

11:4–41.1 Purpose and scope

(a) The purpose of these rules is to implement P.L. 1995, c.73 (the Life and Health Insurance and Health Maintenance Organization Form Approval Reform Act) by setting forth the Department's standards for approval of all individual life insurance forms delivered or issued for delivery in this State.

(b) These rules shall apply to all individual life insurance forms issued pursuant to N.J.S.A. 17B:25–1 et seq.

11:4–41.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Account value policy" means any policy, including, but not limited to, true universal life (flexible premium universal life) and interest sensitive whole life (fixed premium universal life), where benefits (including non-forfeiture or surrender benefits) may be calculated by reference to a policy accumulation account. Policy accumulation accounts reflect the actual premiums paid, actual interest credited, and any mortality or expense charges assessed.

"Act of war" means any act peculiar to military, naval or air operations in time of war.

"Bail-out feature" means a feature whereby the owner may elect to surrender the policy for the cash value without incurring a surrender charge under specified conditions, such as the interest rate(s) credited to the policy falling below a pre-determined rate.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Department" means the New Jersey Department of Banking and Insurance.

"Designated life option" means an option whereby the beneficiary of a policy may purchase a policy on a designated life.

"Field issue" means a contract where, upon acceptance of a premium, the agent issues the contract for delivery in the field rather than from the home office.

"Flexible premium" means a policy where the policyholder is permitted to vary the amount or timing of premium payments subject to any specified limits.

"Home area" means the 50 states of the United States, District of Columbia and Canada.

"Indeterminate premium policy" means a policy where the insurer retains the right to recalculate the premium required to maintain the policy in force on the basis of future or emerging experience. Indeterminate premium policies may or may not be account value policies.

"Insurer" means any person or persons, corporation, partnership or company authorized by the laws of this State to transact the business of life insurance in this State.

"Life insurance" is as defined at N.J.A.C. 11:4–40.2.

"Minimum guarantee provision" means a provision which provides that a policy with a policy value not exceeding zero will not lapse so long as premiums paid to date exceed a target sum of stipulated minimum premiums.

"Minimum premium test provision" means a provision which provides that a policy which uses the account value less surrender charge to determine lapse will not lapse so long as the account value remains positive, and the premiums paid to date exceed a target sum of stipulated minimum premiums.

"Option to suspend premiums" means a premium payment option whereby premiums can be paid from the excess of actual cash value over guaranteed cash value to keep the policy in full force on a premium-paying basis.

"Participating policy" means a policy under which the policyholder is entitled to share in the divisible surplus earnings of the company through dividends.

"Policy split option" means an option where a policy covering multiple lives may be split into policies on the individual lives.

"Policy value" means with reference to grace period, policy loan, and reinstatement provisions, the value calculated from the account value in a manner defined in the policy, which is used in determining whether or not the policy remains in force. As examples, the policy may define this value as the account value less debt, or it may define the policy value as the account value less debt less applicable surrender charges.

"Re–entry or requalification feature" means a feature which provides for lower renewal premiums on satisfactory reunderwriting, for issue of a new policy at lower rates if underwriting requirements are met, or one which by its design invites an insurable policyholder to lapse and purchase the same policy at a new issue age.

"Scheduled premium policy" means a policy whereby the owner is required to pay a premium in a scheduled amount at specific intervals. Such policy provides a traditional grace period and nonforfeiture benefits, and a statutory minimum cash value determined on a prospective basis.

"Substitute insured option" means an option primarily used in keyman insurance whereby an individual is substituted for an insured covered by an in-force policy.

"Surrender charge" means the charge imposed by the insurer upon surrender of a policy before it becomes payable by maturity or occurrence of the circumstance insured against.

"Vanish premium option" or "VPO" means a non-forfeiture option whereby extended term insurance is provided for a non-guaranteed period with an option to extend the term through payment of additional premiums.

"War" includes, but is not limited to, declared war, and armed aggression by one or more countries resisted on orders of any other country, combination of countries or international organization.

Amended by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).

11:4–41.3 General standards

(a) No individual life insurance policy, rider, application or endorsement shall contain provisions which are unjust, unfair, inequitable, misleading, contrary to law or to the public policy of this State.

(b) The following approval standards shall apply to all individual life insurance forms:

1. All forms shall include a provision for a period of time during which the policy may be reviewed and subsequently cancelled by the policyholder free of charge or penalty.

i. This period of free review shall be no less than 10 days, and shall not exceed one year from the date the policy was received by the policyholder.

ii. Policies which provide for a cash value which is equal to the return of all gross premiums paid shall be considered to contain an extended free review period or additional review period. The provision which allows for such a defined cash value is subject to the time limits of (b)1i above.

2. All forms shall include a provision for a grace period within which overdue premiums may be paid and the policy shall continue in force.

i. Payment of the overdue premium shall be effected on the date of mailing of the payment by the policyholder and may be made at any time during the grace period.

ii. The grace period provision shall not require receipt of the premium by the insurer within the grace period. The policyholder shall have the entire period within which to remit payment. The insurer may rely on the postmark to determine payments.

iii. Premiums due during a grace period may be subjected to an interest charge not exceeding six percent per annum for the number of days of grace elapsing before the payment of the premium. Any such interest charge shall be so stated within the grace period provision.

iv. If a claim arises during a grace period, any premium due or overdue together with interest owed, if any, may be deducted from the amount payable under the policy. If such a deduction is to be effective, the grace period provision shall include a statement to that effect.

v. For all policies which remain in force by payment of a required or stipulated premium, the grace period shall be no less than 30 days.

vi. For account value policies kept in force by a policy value exceeding zero, the grace period shall be determined by one of the following two methods:

(1) No less than 30 days following the date on which the policy value is equal to zero; or

(2) No less than 60 days following the first monthly deduction date for which the policy value is insufficient to provide an entire additional month of insurance.

vii. The grace period provision shall not allow the grace period to be preempted by a termination of the policy due to excessive loans, but shall be in addition to any and all protections provided to the policyholder under the policy loan provisions set forth at (b)7 below.

3. All forms shall include a provision that the policy shall become incontestable by the insurer, except for nonpayment of premiums, after the policy has been in force during the lifetime of the insured for a period of no more than two years from the date of the policy's issue.

i. The periods for incontestability and suicide shall commence upon the earliest of the date of issue, the policy date and any other effective date. As used in this subchapter, the date of issue or date of the policy's issue shall be deemed to be the earliest of the date of issue, the policy date and any other effective date described in the form, except in the case of backdating to save age where the date of issue or date of policy's issue shall be the date on which coverage becomes effective.

ii. For modifications increasing the death benefits of the policy, or reducing the premiums of the policy, the following limits upon the right to contest apply:

(1) If the insurer intends to retain a right to contest claims following such modifications in the policy which are based upon additional evidence of insurability, the form shall contain a statement to that effect. Otherwise, such right is deemed waived.

(2) If the insured is reclassified as a non-smoker at a reduced premium based upon additional evidence of insurability, the insurer may reserve a right to contest the policy for no more than an additional two years following the date of reclassification, but only with regard to the amount of insurance attributable to the reduction in premium.

(3) If increased amounts of insurance are purchased subject to additional evidence of insurability, the insurer may reserve a right to contest the policy for no more than an additional two years following the date of the purchase of the increase, but only limited to the actual increase in insurance.

(4) Insurers shall not retain any right of contest when modifications to the policy occur without additional evidence of insurability, such as corridor or cost of living increases.

iii. The standards for policies which provide a reentry or requalification feature set forth at N.J.A.C. 11:4–41.14 are expressly incorporated herein.

iv. The following are standards for any contestability and suicide provisions which commence following a change of plan or conversion:

(1) If evidence of insurability is not required for change of plan or conversion and such change or conversion occurs within two years from the original date of issue, then the insurer may continue to contest the original application for two years from the original date of issue (provided that the original application is part of the new policy).

(2) If evidence of insurability is required for a change of plan or conversion, contestability shall be limited only to the evidence given in the application for the new policy for the two-year period following its issue. If the original application is made part of the application for the new policy, evidence included in such original application shall not be contestable after two years from the original date of issue.

(3) For any change of plan or conversion not involving an increase in the amount at risk, the period for death by suicide under the new policy shall

begin as of the date of issue of the original policy. A new two-year period may be imposed on any increase in the amount at risk.

(4) The provision describing the change of plan or conversion shall clearly state whether or not evidence of insurability is required for the change of plan or conversion, and shall include details of any new contestable or suicide period following such change of plan or conversion.

v. The following requirements apply to substitute insured options:

(1) The substitution may result in a suicide and contestable period applying to the substitute insured.

(2) The minimum amount which shall be payable upon a contested claim or death by suicide for a substitute insured shall be at least equal to the cash value of the original policy as of the date of substitution plus premiums paid to the date of death, adjusted for loans, dividends, or partial surrenders.

(3) The option shall disclose whether a new period for contestability or suicide commences upon substitution, and shall describe the settlement for a contested claim or death by suicide.

4. All forms shall include a provision that the policy and any application therefore, if a copy of the application is attached to or endorsed upon the policy, shall constitute the entire contract between the parties, and that all statements contained therein shall, in the absence of fraud, be deemed representations and not warranties. This provision shall additionally include a statement that any applications for modifications in the policy, which are to be based upon additional evidence of insurability, shall be attached to the policy in order to become part of the contract between the parties, or the insurer shall be deemed to have waived any right to contest any modification made on the policy.

5. All forms shall include a provision for the redetermination of benefits on a policy if the age of the insured or of any other person whose age is considered in determining the premium or benefits of the policy has been misstated.

i. For benefits arising from the payment of required or stipulated premiums, the insurance benefit shall be reduced or increased to the amount of coverage that would have been purchased by the premiums paid based on the corrected age.

ii. If the misstatement of age results in an issue age which is not within the insurer's range of insurance issue ages for that policy form, the insurer shall extrapolate a premium and benefit. The provision for misstatement of age shall not state that the policy will be rescinded and the premiums refunded.

iii. For benefits arising from the account value on account value policies, the insurer shall provide for adjustment of benefits by one of the two methods below:

(1) The insurer may recalculate all policy values since the inception of the policy to the extent that the recalculation, in and of itself, shall not result in termination of the policy prior to the date of death. The amount payable at death on the policy after recalculation shall not be less than the cash value would have been on the date of death based upon the misstated age. The insurer shall assume when making an adjustment at the time of surrender, maturity, or death that the death benefit in all preceding years is the actual death benefit which would have been paid under the corrected age of the insured had death occurred in any preceding year.

(2) The insurer may provide that the adjusted death benefit shall be that amount which would have been purchased at the correct age in consideration of the most recent mortality charge, in which instance the insurer shall not make any retrospective recalculations to the accumulation value or cash surrender value. The insurer may adjust future months' deductions so as to reflect the corrected age.

iv. If the insurer includes a provision for policy adjustments utilizing (b)5iii(1) above, the insurer shall include in the submission an actuarial memorandum prepared by a certified actuary with examples of the method for recalculation since inception.

v. An account value policy, which stays in force through the payment of required or stipulated periodic premiums and which provides a guarantee of benefits if these premiums are paid, shall adjust the guaranteed benefits in accordance with (b)5i and ii above. Benefits arising from the account value shall be adjusted in accordance with one of the methods set forth in (b)5iii above.

vi. The policy provision concerning adjustment due to misstatement of age shall describe how all policy benefits are redetermined.

6. All participating policy forms shall contain a provision that beginning on or before the end of the third policy year, the insurer shall annually ascertain and apportion the divisible surplus, if any, accruing on the specified dividend date, which may be the policy anniversary date.

i. At the option of the policyholder, dividends on all policies shall be:

(1) Payable in cash; or

(2) Applied to any of such other dividend options as provided for under the policy.

ii. The policy provision shall disclose which specific dividend option shall become effective if the policyholder makes no option election within the election period.

iii. The election period shall be specified on the policy as no less than 30 days following the date on which the dividend is due and payable.

iv. Insurers may use the direct recognition of loans in the calculation of dividends. Such methodology may be used without disclosure in the form.

7. All forms, other than those for term insurance in which no policy loan is provided, shall include a provision setting forth the descriptive loan value of the policy and the terms for any policy loan, including automatic premium loans, if so permitted under the policy.

i. The policy loan interest rate shall be stated in the policy either as a fixed maximum interest rate or as a variable rate of interest.

ii. If the interest rate is expressed as a variable interest rate, the policy shall contain a description of the manner in which the rate is calculated and a statement that the rate of interest shall not exceed the higher of the following:

(1) Moody's Corporate Bond Yield Average, based on the Monthly Average Corporates for the calendar month ending two months before the date on which the rate is determined; or

(2) The rate used to compute the cash surrender values under the policy during the loan period plus one percent per annum.

iii. The provision shall include a statement setting forth the frequency at which the interest rate will be redetermined.

(1) The frequency shall be no less than once every 12 months, but no greater than once every three months.

(2) If the rate is redetermined more frequently than annually, or annually on other than a policy year basis, the policy form shall include a statement that the policy shall not terminate in any policy year solely as a result of a change in the interest rate during that year.

iv. The provision shall reserve to the insurer the right to defer the granting of a loan, other than for the payment of premium to the insurer, for six months after submission of a policy loan application.

v. If the policy provides for automatic premium loans, the form shall include a statement as to whether the automatic premium loan is subject to policyholder election.

(1) The form shall be clear in describing the premium mode to be loaned automatically and shall state what shall occur if the loan value available is insufficient for the designated premium mode.

(2) Automatic premium loans based on a day-to-day calculation shall be calculated in accordance with correct actuarial principles so that the first approximation shall allow for the proportionate increase in cash value due to the crediting of a partial premium.

(3) Any submission of a form providing for day-to-day coverage under an automatic premium loan shall contain a numerical demonstration that the method of calculating such coverage is actuarially sound.

vi. Where termination may occur due to excessive debt, the form shall state that the policyholder will be provided with a notice of termination no later than 30 days prior to the date of termination. This notice shall be in addition to the grace period provided under the policy when the policy value becomes zero due to excessive indebtedness in accordance with (b)2 above. Termination due to excessive indebtedness shall not preempt such a grace period.

vii. If the interest rate is expressed as a variable interest rate, the insurer shall:

(1) Notify the policyholder in writing of the initial rate of interest at the time of a cash loan or as soon thereafter as practicable, but in no event later than 30 days following the loan.

(2) Notify the policyholder in writing of the initial rate of interest on the initial automatic premium loan as soon as practicable, but no later than 30 days following the loan.

(3) Notify the policyholder in writing at least 10 days prior to the effective date of any increase in the interest rate.

8. All forms which require or allow a specified premium to be paid at specified intervals in order for the policy to remain in force shall include a provision for reinstatement of the policy upon written application therefor at any time within three years from the due date of the first premium in default.

i. The provision may exclude reinstatement if:

(1) The policy has been surrendered for its cash surrender value;

(2) The policy was not surrendered, but its cash surrender value has been exhausted; or

(3) The paid-up term insurance, if any, has expired.

ii. Any requirement by the insurer for new evidence of insurability shall be stated clearly in the reinstatement provision.

iii. The provision shall state the amount to be paid to reinstate the policy, and shall include references to the following, as applicable:

(1) Payment of premiums in arrears;

(2) Payment (or reinstatement) of any loans;

(3) Interest at a specified rate on (b)8iii(1) and (2) above.

iv. If the policy has a variable policy loan interest rate, then the reinstatement provision shall describe the loan interest rate which will be applied to any loans reinstated or paid upon reinstatement of the policy.

v. An account value policy which stays in force as long as the policy value is positive may include a reinstatement provision, which shall comply with (b)8ii and iv above, in addition to the following:

(1) Reinstatement shall be offered for a period of three years from the date of default.

(2) The form shall clearly describe the amount necessary to reinstate. The company may require that monthly deductions be paid in advance for a specified number of future months, and that the monthly deduction for any grace period be paid. Monthly deductions cannot be charged for the period of default beyond the grace period.

(3) The form shall state whether minimum premium guarantees, if any, will be reinstated or may otherwise be reinstated subject to payment or prepayment of additional premiums.

(4) If the policy imposes surrender charges on the account value, the reinstatement provision shall state whether and in what manner surrender charges will be imposed on the reinstated policy. Otherwise, no surrender charges shall be applicable with respect to the reinstatement policy.

9. All forms shall include a provision which sets forth the premiums payable at all durations in order to maintain the policy in force.

i. Forms shall not include any provision which permits the insurer to arbitrarily refuse premium payments.

ii. Forms shall include any upper and/or lower limits on premium payments. The maximum premium payment for a flexible life insurance policy shall not be lower than the amount which will continue to qualify the policy as life insurance or the amount necessary to keep the policy in force, if greater.

iii. Payment of premiums may be made by credit card. Submissions of forms which permit payment by credit card shall include a certification from an officer of the insurer that the premium will be considered paid when the credit card facility is billed.

iv. If, in order to prevent lapse of a policy, a premium is paid automatically by charging against the policy's loan value, the insurer shall provide written notice to the policyholder. Said notice shall include the amount of the loan and the interest rate, and shall be mailed no later than 30 days after the end of the grace period of the premium paid by loan.

v. The following requirements apply to policies with a vanishing premium option:

(1) The option shall be presented as one of the non-forfeiture options available on non-payment of premium. The option shall not be automatic. If this option is not elected by the owner, one of the traditional non-forfeiture options shall be provided.

(2) The reinstatement provision shall clearly apply to policies in force under the vanishing premium option.

(3) While this provision is in effect, the policy shall limit additional premium payments to the amount necessary to restore the account value to an amount sufficient to provide paid-up life insurance on a current assumption basis.

(4) If no additional premiums are made and the account value no longer provides continued coverage on a current basis, the coverage shall be deemed extended term.

(5) The period of extended term coverage on a guaranteed basis shall not be less than would be obtained by applying the cash surrender value as a net single premium under a traditional extended term option.

vi. The following requirements apply to policies with an option to suspend premiums:

(1) An option to suspend premiums shall be presented as a premium option exercised to maintain the policy in force on a premium-paying basis.

(2) Premiums shall be paid only from the excess of the actual cash value over the guaranteed cash value. Premiums shall not be paid from the guaranteed cash value. The prospective guaranteed cash value shall be maintained since the policy is being maintained on a premium paying basis.

(3) When an additional premium is due in order to keep the policy in force on a premium paying basis, the insurer shall mail a notice to the policyholder no sooner than 30 days before the premium due date. A grace period of 60 days from the mailing date of the notice shall be provided for payment of the premium. The additional premium due cannot exceed the guaranteed premium for the policy. The premium mode, for purposes of premium due date and amount of premium, shall be that selected by the policyholder.

(4) If the additional premium to keep the policy in force on a premium-paying basis is not paid within the grace period, the usual non-forfeiture provision shall apply unless automatic premium loan has been included to protect against lapse. These provisions shall include rights to reinstatement required by law for lapsed policies.

(5) Additional premiums shall not be permitted after the policy has lapsed and entered into a non-forfeiture mode.

vii. Account value policies kept in force by a policy value exceeding zero shall be permitted to contain a minimum guarantee provision. Account value policies which use the account value less surrender charge to determine lapse shall also be permitted to contain a minimum premium test provision. The following requirements shall apply to minimum guarantee provisions and minimum premium test provisions:

(1) Minimum guarantee provisions shall indicate that, on a guaranteed basis, the policy value at the end of the guarantee period may be insufficient to keep the policy in force unless an additional payment is made at that time. A similar provision, if applicable, is required for policies with minimum premium tests. This requirement shall not be applicable to minimum guarantee premiums or test premiums if the policy value at the end of the guarantee period (assuming payment of the minimum guarantee or test premiums and guaranteed credits and charges) is sufficient to prevent lapse. This will typically be the case for minimum premium tests if the surrender charges are zero by the end of the guarantee period.

(2) Any policy to which (b)9vii(1) above applies shall indicate, on the same page as a minimum guarantee premium or minimum test premium, the maximum amount (based on policy guarantees) required to be paid at the end of the guarantee period to keep the policy in force assuming continuation of the initial death benefit, payment of minimum guarantee premiums, and no policy loans or partial withdrawals. This requirement applies only to those policies to which requirement (b)9vii(1) above applies.

(3) The minimum premiums shall be measured cumulatively rather than payable on a periodic basis. The minimum premium test shall not be made periodically, but shall only be made at the time of lapse. However, the required cumulative minimum premiums and cumulative premiums paid may be adjusted with interest at the guaranteed crediting rate.

(4) The policy shall provide for a grace period with respect to payment of minimum premium consistent with N.J.S.A. 17B:25–3. (For example, the 61 day grace period usually found in flexible premium universal life policies should allow the minimum premiums to be paid to keep the contract in force as an alternative to the monthly deduction or other amount specified.)

(5) If the minimum premium guarantee allows a policy to remain in force with a negative account value, then no interest may be "credited" to that account value (resulting in an interest charge), and the cost of insurance charge cannot increase the net amount at risk to reflect the negative account value.

(6) Policies with long term guarantees (that is, 25 years or 20 years at older issue ages) shall provide a non-forfeiture value no less than the traditional non-forfeiture value which would be required for that plan of term insurance.

(7) The grace period for the policy shall be coordinated with the grace period provided for the minimum premium. The amount required to avoid lapse shall be the amount required to fund the minimum premium or the amount required to pay any balance due for the cost of insurance, whichever is less. This required amount is the amount to be deducted from any death claim during the grace period.

10. All forms shall contain a provision that settlement of a claim which becomes payable by reason of the death of the insured shall be made upon receipt of due proof of death.

i. The insurer may require surrender of the policy or proof of the interest of the claimant, or both, and shall state in the claims payment provision that such proof may be required.

ii. The insurer may specify in the claims payment provision a period of delay for settlement of claims, but in no event shall the period specified exceed two months from the date of the submission of the proof of a claim.

11. All forms shall include a title appearing on the face page of the policy which shall briefly describe the policy, shall not be misleading and shall state if the form is participating or nonparticipating or words of similar meaning.

12. All forms may contain a provision addressing contestability and liability limitations of the policy following reinstatement. If the form does not contain such a provision, the policy shall be incontestable from the date of reinstatement, and limitations on liability shall be waived.

i. The provision for contestability of the reinstated policy shall be no less favorable than the provision for contestability of the policy following original issue.

ii. The provision may restrict liability of the insurer on a reinstated policy which is effective from the date of reinstatement, but which restricts or excludes liability only to the extent that such liability is excluded or restricted on the policy as originally issued.

Amended by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
Rewrote (b).

11:4–41.4 Exclusions and prohibitions

(a) The Department shall permit the following exclusions for coverage:

1. Aviation exclusions;

2. Avocation exclusions;

3. War risk exclusions, which may include military, non-combatant civilian and civilian exclusions.

i. Regarding military exclusions, risk of death may be excluded under the following conditions:

(1) As a result of war or act of war, if the cause of death occurs while the insured is serving in the military, naval or air forces of any country, combination of countries or international organization, provided such death occurs while in such forces or within six months after termination of service in such forces; or

(2) As a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the cause of death occurs while the insured is serving in such forces and is outside the home area, provided such death occurs outside the home area or within six months after the insured's return to the home area or area in such forces or within six months after the termination of service in such forces, whichever is earlier.

ii. Regarding non-combatant exclusions, risk of death may be excluded under the following conditions:

(1) As a result of war or an act of war while the insured is serving in any civilian non-combatant unit serving with such forces, provided such death occurs while in such units or within six months after termination of service in such units, whichever is earlier.

(2) As a result of the special hazards incident to service in any civilian non-combatant unit serving with such forces, if the cause of death occurs while the insured is serving in such units and is outside the home area, provided such death occurs outside the home area or within six months after the insured's return to the home area in such units or within six months after the termination of service in such units, whichever is earlier.

iii. Regarding civilian exclusions, risk of death may be excluded under the following conditions:

(1) As a result of war or an act of war, within two years from the date of issue of the policy, while the insured is not in such forces or units, if the cause of death occurs while the insured is outside the home area, provided such death occurs outside the home area or within six months after the insured's return to the home area.

iv. Any amount payable as a result of death from an excluded act shall be at least equal to the greater of the premiums paid for the policy or the reserve, each adjusted for dividend values, loans, partial withdrawals and surrenders.

v. The filing of any rider or policy provision which provides for a war risk exclusion, an aviation exclusion and/or an avocation exclusion shall be subject to the requirement that the policyowner shall in each case be duly notified of the exclusion, and that the method of notification for a war risk exclusion shall be in the form of a stamp across the face of the policy.

11:4–41.5 Prohibition of bail-out features

Bail–out features shall not be permitted.

11:4–41.6 Indexed benefits

Any form which describes death benefits or credited interest in terms of a published index shall state how death benefits and interest shall be determined upon the discontinuance of the index, and that any substitute index is subject to Department approval.

11:4–41.7 Standards for pre-existing conditions exclusions

(a) Pre–existing condition exclusions shall only be permitted in the case of benefits for disability, as follows:

1. The insurer shall not be liable for a disability resulting from any pre-existing condition which is disclosed in the application and excluded by rider.

2. The insurer shall be liable from the effective date of the policy for a disability resulting from any pre-existing condition which is in an application and not excluded by rider.

3. The insurer shall not be liable for any pre-existing condition which is not disclosed in the application because the application did not include such a question and because of which the insured becomes disabled during the first two years of the effective date of the policy. The insurer shall be liable if the insured recovers from such disability and becomes disabled again from the same pre-existing condition after two years from the effective date of the policy.

4. The insurer shall be liable for any pre-existing condition which is not disclosed in the application because the application did not include such a question and because of which the insured becomes disabled two or more years after the effective date of the policy.

5. The insurer may contest a material misrepresentation made by the insured in the application.

11:4–41.8 Standards for field issue contracts

(a) Use of the same form for field issue and home office issue contracts shall not be permitted.

(b) The following requirements shall apply to field issue contracts:

1. The application shall not be substituted for or obscure the policy face page.

2. The application and policy shall not be featured as one form. Separate identifying form numbers and submissions for the application and policy form are required.

3. Submissions of field issue forms shall include a certification from an officer of the insurer that the insurer will be bound by all information recorded by the agent on the application, including, but not limited to, the initial interest rate and the initial interest rate guarantee period, even in the case of errors.

4. Coverage under the form shall be effective no later than the date the policy is delivered to the owner. The form may not provide a delayed or deferred effective date or be conditionally effective.

5. Suicide and contestability provisions shall commence no later than the effective date of coverage.

11:4–41.9 Standards for other insured coverage

(a) The following standards shall apply to other insured coverage, which provides coverage to an insured other than the policy's primary insured:

1. The form shall clearly describe what happens to the insurance on the other insured upon the death of the primary insured.

2. If coverage on the other insured terminates upon the death of the primary insured, then the form shall provide for the return of the unearned premium (or cost of insurance). Alternatively, the form may continue coverage on the other insured for the remainder of the period purchased by the premium (or cost of insurance).

3. The form may continue the coverage on the other insured by waiver of premium (or cost of insurance).

4. The form may continue the coverage on the other insured through paid-up term insurance. In such a case, the form shall include the following:

i. A description of the basis for calculating the cash value of such paid-up insurance;

ii. A statement that the paid-up insurance may be surrendered at any time for its cash value; and

iii. A statement that if the paid-up insurance is surrendered within 30 days after a policy anniversary, the value available shall not be less than the anniversary value.

5. The form may continue coverage on the other insured as paid-up term insurance evidenced by a separate policy to be issued by the insurer.

Recodified from N.J.A.C. 11:4–41.11 by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
Former N.J.A.C. 11:4–41.9, Standards for extension or cancellation of maturity dates, repealed.

11:4–41.10 Standards for survivorship forms

(a) The following requirements shall apply to survivorship forms, which provide that the death benefit is payable on the last surviving insured:

1. For any survivorship form with cash values, the values shall be calculated using exact ages, sexes and underwriting classifications. Equivalent ages or approximations may be used and will be reviewed on a case-by-case basis.

2. The form or actuarial memorandum shall describe any modifications to the published tables. If the actuarial memorandum is used to describe the modification(s), then the form shall state that a detailed statement is on file with the Department.

(b) Survivorship forms shall satisfy the following requirements regarding contestability:

1. Provisions are permitted which state that the form is incontestable after it has been in effect during the lifetime of the surviving insured for two years; and

2. Provisions are permitted which state that, with respect to each insured, coverage is incontestable after it has been in effect during the lifetime of that insured for two years, but only if the following requirements are met:

i. The insurer shall provide written notice to the policyowner at the end of the second policy year requesting that the policyowner notify the insurer of the death of any insured. The notice shall additionally state that failure to provide notice of death will not preclude a contest, and could result in a contest even if premium payments continue to be made. A sample copy of the notice shall be submitted for Department review;

ii. The contestability provision in the form shall describe the mailing of the notice in (b)2i above and shall state the adverse implications for the policyowner's failure to provide the insurer with timely notice of death;

iii. A copy of the insurer's notice and any policyowner reply shall remain on file with the insurer; and

iv. Any action of contest shall commence promptly upon notice of death.

(c) Survivorship forms shall satisfy the following requirements on suicide:

1. The insurer shall be permitted to rescind a contract as a result of suicide when both insureds or the surviving insured commit suicide during the first two years;

2. Except as provided in paragraph (c)3 below, the insurer shall reform and reissue the contract as of the original effective date as a single life contract on the surviving insured where only the first insured to die commits suicide during the first two years.

i. The insurer shall provide the single-life coverage automatically without evidence of insurability, which shall be substantially the same as the coverage provided under the original survivorship policy.

ii. Any suicide and contestability provisions of the reformed and reissued contract shall be effective as of the effective date of the original survivorship form;

3. As an alternative to the reformed and reissued contract, the insurer shall be permitted to continue the original policy as a survivorship contract.

i. The form's suicide provision shall include a description of either the reformed and reissued contract at (c)2 above, or the survivorship contract at (c)3 above;

4. Insurers shall be permitted to avoid the provision of single life coverage on the life of the survivor only if such surviving insured was uninsurable at the time the original policy was issued and the form so states; and

5. Any time limits with respect to the process of changing coverage from joint to single life coverage shall satisfy the following standards:

i. The suicide provision shall include the requirement that proof of first death shall be provided to the insurer. In the case of first death by suicide, such proof shall be provided within 90 days of the death;

ii. The provision shall indicate that the insurer shall provide information no later than 30 days after receiving notification of the death regarding any payments required for the single life coverage (for example, the new premium amount) which may be required;

iii. The provision shall allow the owner a 60–day period after receiving notification from the insurer to pay the amount(s) required; and

iv. The provision shall describe the death benefit payable in the event the survivor dies prior to expiration of the 60–day period allowed for payment without having made the payment. Such death benefit shall be based on the full face amount of the original survivorship policy net of the premium and any other required amount remaining due and payable.

(d) Insurer contestability and suicide practices for riders used with survivorship contracts shall be consistent with those for the base policy.

(e) The form shall include a provision directing the owner to submit to the insurer proof of death upon the first death.

Recodified from N.J.A.C. 11:4–41.13 by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
Former N.J.A.C. 11:4–41.10, Standards for policy split options, repealed.
Amended by R.2001 d.100, effective March 19, 2001.
See: 32 N.J.R. 4045(a), 33 N.J.R. 1006(a).
Rewrote (c)4.

11:4–41.11 Standards for re-entry or requalification features

(a) The following standards shall apply to coverage which provides a re-entry or requalification feature:

1. The Department shall require a certification that the insurer will not attempt to defeat the requalification provision by markedly altering its underwriting standards between the time of issue and the time of requalification. In this context, a change in the underwriting standards refers to the level of expected mortality needed to requalify, and not to the tests or information used to arrive at this estimate of expected mortality.

2. The percentage of insureds requalifying shall not be used as a basis for changing any indeterminate premium.

3. The current premiums for insureds not requalifying shall be based on realistic assumptions which reflect the anti-select nature of this risk pool.

4. The provision describing requalification shall state whether such requalification is contestable or subject to a new suicide period.

5. If requalification involves a reduction in premium on the same policy to a level below the premium which would have been charged without underwriting, then only the difference in the policy face amount which is attributable to the difference in premium shall be contestable for up to two years following the date of re-entry, if any right to contest is reserved.

6. If requalification requires issuance of a new policy at current rates, the entire contract may be contestable for up to two years following the date of requalification, if so stated. Such a transaction shall be a replacement and the insurer shall be required to satisfy the requirements of N.J.A.C. 11:4–2. Insurers shall include specimen copies of disclosure forms with their forms submission to the Department.

Recodified from N.J.A.C. 11:4–41.14 by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
Former N.J.A.C. 11:4–41.11, Standards for other insured coverage, recodified to N.J.A.C. 11:4–41.9.

This (policy/certificate) is (primary/secondary) to OSAIC. (However, if the OSAIC contains provisions which make it secondary or excess to the policyholder's Plan, then the policyholder's Plan will be primary.) Omit if the policyholder's Plan is elected as primary coverage.

(If the policyholder's Plan is one of several insurance plans which provide benefits to the insured and are primary to automobile insurance coverage, then the rules as provided in the Coordination of Benefits section of this (policy/certificate) shall apply.) Omit if policyholder's Plan does not contain a COB provision.

If there is a dispute as to whether the policyholder's Plan is primary or secondary, this (policy/certificate) will pay benefits as if it were primary.

4. Benefits we will pay if the Plan is primary to PIP or OSAIC.

If the policyholder's Plan is primary to PIP or OSAIC, this (policy/certificate) will pay benefits payable on eligible expenses in accordance with the terms provided in this (policy/certificate).

5. Benefits we will pay if the Plan is secondary to PIP.

If the policyholder's Plan is secondary to PIP, the actual benefits payable will be the lesser of: (i) the remaining uncovered allowable expenses after PIP has provided coverage after application of deductibles and copayments, or (ii) the actual benefits that would have been payable had the policyholder's Plan been providing coverage primary to PIP.

6. Medicare.

To the extent that the (policy/certificate) provides coverage that supplements coverage under Medicare, then the policyholder's Plan can be primary to automobile insurance only insofar as Medicare is primary to automobile insurance.

SUBCHAPTER 43. INDIVIDUAL ANNUITY CONTRACT FORM STANDARDS

11:4–43.1 Purpose and scope

(a) The subchapter implements P.L. 1995, c.73, by setting forth standards and requirements that individual annuity contract forms delivered or issued for delivery in this State are required to satisfy in order to obtain approval from the Commissioner.

(b) This subchapter shall apply to all individual annuities issued pursuant to N.J.S.A. 17B:25–18 and P.L. 1995, c.73, sections 16 and 17.

11:4–43.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Annuity" means a contract not included within the definition of life insurance as set forth in N.J.S.A. 17B:17–3, or health insurance as set forth in N.J.S.A. 17B:17–4, under which an insurer obligates itself to make periodic payments for a specified period of time, such as for a number of years, or until the happening of an event, or for life, or for a period of time determined by any combination thereof.

"Bail–out feature" means a feature whereby the owner may elect to surrender the contract for the cash value without incurring a surrender charge under specified conditions, such as the interest rate(s) credited to the contract falling below a predetermined rate.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Deferred annuity" means an annuity where the first annuity payment is due no earlier than one year from the issue date of the contract, and the annuity is not an immediate annuity.

"Department" means the New Jersey Department of Banking and Insurance.

"Field issue" means a contract that the agent, following acceptance of a premium, issues for delivery in the field rather than from the home office.

"Flexible premium" means a contract where the policyholder is permitted to vary the amount and timing of premium payments, subject to any specified limits.

"Immediate annuity" means an annuity where the first annuity payment is due not more than 13 months from the issue date of the contract.

"Insurer" means any person or persons, corporation, partnership, or company authorized or admitted to transact the business of life insurance or annuities in this State pursuant to Title 17B of the New Jersey statutes.

Amended by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).

11:4–43.3 General requirements and prohibitions

(a) All individual annuities shall be filed with the Commissioner pursuant to N.J.S.A. 17B:25–18; P.L. 1995, c.73, sections 16 and 17; and N.J.A.C. 11:4–40 prior to being delivered or issued for delivery in this State.

(b) Individual annuity contract forms shall not contain any provisions which are unjust, unfair, inequitable, ambigu-

ous, misleading, likely to result in misinterpretation or are contrary to law.

(c) All individual annuities shall satisfy the following conditions:

1. If a form guarantees an interest rate of less than three percent during the accumulation phase, the insurer shall include with the submission a demonstration that policy values and benefits are not less than the minimum nonforfeiture amounts specified in N.J.S.A. 17B:25–20g.

2. If a form offers varying interest rate guarantee periods, specimen specification pages shall be submitted for each of the various guarantee periods.

3. The same contract form shall not be issued as both an immediate and a deferred annuity.

(d) An insurer shall not use the same form for field issue and home office issue contracts.

1. The application and policy for field issue individual annuities shall be submitted as separate forms with separate identifying form numbers. The application shall not be substituted for or obscure the policy face page.

2. Coverage under a field issue contract shall be effective no later than the date the policy is delivered to the owner. Field issue contracts shall not provide for delayed, deferred or conditional effective dates. Suicide and contestability periods shall commence no later than the effective date of coverage.

3. Submissions of field issue forms shall include a certification from an officer of the insurer that the insurer will be bound by all information recorded by the agent on the application, including, but not limited to, the initial interest rate and the initial interest rate guarantee period, even in the case of errors.

(e) Payment of premiums for individual annuities may be made by credit card. Submissions of forms which permit payment by credit card shall include a separate certification from an officer of the insurer that the premium will be considered paid when the credit card facility is billed.

Amended by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
In (c), deleted a former 1, recodified former 2 through 4 as 1 through 3, and deleted a former second sentence in the new 2.

11:4–43.4 Individual immediate annuities

(a) Individual immediate annuity contracts which include surrender benefits, partial withdrawals or indeterminate annuity payments other than commutation rights shall meet or exceed the requirements of the Standard Nonforfeiture Law for Individual Deferred Annuities at N.J.S.A. 17B:25–20. Submissions of such forms shall include a demonstration of compliance with this requirement.

(b) The premium for an immediate annuity shall be paid in a lump sum, and shall not be funded on an installment basis.

(c) If an immediate annuity provides a commutation privilege for the owner, the commutation interest rate shall be within one percent of the rate used in calculating the single premium.

11:4–43.5 Individual deferred annuities

(a) Insurers shall include a provision in all individual flexible premium annuity forms specifying any upper and/or lower limits on premium payments, and shall not arbitrarily refuse premium payments.

(b) An annuity form shall not be identified as a single premium contract if it contains a provision for additional premiums.

(c) An annuity form shall not permit a single premium annuity to be paid in installments.

(d) Insurers shall provide written notice to all prospective purchasers of individual flexible premium annuities at or before application. The notification form shall be submitted to the Department upon filing any individual flexible premium annuity form. The written notice shall include the following:

1. A statement that cash values under a flexible premium annuity where only one premium is paid can be lower than those under a single premium annuity, and that purchase of a flexible premium annuity may be inappropriate in such a case; and

2. A signature by the purchaser.

(e) The requirements at (d) above shall be waived if the insurer includes in its submission a separate actuarial memorandum which demonstrates that the values provided under the form on the guaranteed basis equal or exceed minimum values as described at N.J.S.A. 17B:25–20g for both a single premium or flexible premium contract.

(f) An individual deferred annuity form which describes credited interest in terms of a published index shall state how interest shall be credited upon the discontinuance of the index, and that any substitute index is subject to Department approval.

11:4–43.6 Waiver of surrender charges

(a) An individual annuity form which includes a waiver of surrender charges upon confinement to a nursing home or similar institution shall comply with the following requirements:

1. The benefit shall be limited to the confinement of the owner or annuitant. Confinement of any other family member who is not an owner or annuitant identified in the contract shall not qualify for the benefit.

(b) An individual annuity form which provides a waiver of surrender charges for an occurrence of terminal illness shall comply with the following requirements:

1. The form shall not require that the cause of the terminal condition first manifest itself or be diagnosed after issuance of the policy or rider in order to provide entitlement to the benefit;

2. The form shall not limit the benefit to specified diseases;

3. The form shall state that any requirements for a second or third medical opinion to confirm the terminal illness shall be at the insurer's expense; and

4. The form shall limit the benefit to the terminal illness of the owner or annuitant. Terminal illness of any other family member not an owner or annuitant identified in the contract shall not qualify for the benefit.

(c) Any individual annuity form which permits penalty-free partial withdrawals or surrenders shall clearly describe the amount available for such penalty-free withdrawal or surrender. The form shall specifically state when the contract value used in the calculation of the penalty free amount is determined.

(d) The individual annuity form shall not provide for retroactive assessment of a surrender charge to recover any prior surrender charge which was waived by the insurer as a result of confinement or terminal illness or a penalty-free withdrawal or surrender.

Amended by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
In (a), deleted former 1 and 2 and recodified former 3 as 1; and in (b), deleted former 1 and 2 and recodified former 3 through 6 as 1 through 4.

11:4–43.7 Surrender charges for individual deferred annuities

Submissions of all individual deferred annuity contracts having a separate surrender charge associated with each premium payment shall include an actuarial certification that surrender charges in later years comply with N.J.S.A. 17B:25–20.

Amended by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
Rewrote the section.

SUBCHAPTER 44. STANDARDS FOR CONTRACTS ON A VARIABLE BASIS

11:4–44.1 Purpose and scope

(a) The purpose of this subchapter is to implement the Life and Health Insurance and Health Maintenance Organization Form Approval Reform Act, P.L. 1995, c.73, by setting forth the Department's standards for approval of life insurance and annuity contracts issued on a variable basis.

(b) This subchapter shall apply to all life insurance and annuities contracts on a variable basis and any certificate evidencing variable benefits pursuant to such contracts, which are issued pursuant to N.J.S.A. 17B:28–1 et seq. and delivered or issued for delivery in this State.

11:4–44.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Contract on a variable basis" or "variable contract" means any separate account contract providing for the dollar amount of life insurance or annuity benefits or other contractual payments or values thereunder to vary so as to reflect investment results of one or more separate accounts in which amounts with respect to any such contracts have been placed. Market value adjusted annuities are included within this definition, and are not fixed annuities.

"Department" means the New Jersey Department of Banking and Insurance.

"Market value adjusted annuity" means a deferred annuity containing a long-term substantial interest rate guarantee which provides for adjustment of the cash value prior to the maturity of the guarantee to reflect the market value of the guarantee. The market value of the guarantee is generally the present value of the guaranteed rate using the current interest rate being credited on similar contracts with similar maturities.

"Separate account" means any segregated portfolio of investments or designated account of an insurer established pursuant to N.J.S.A. 17B:28–1 et seq.

Amended by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).

11:4–44.3 Standards for variable contracts

(a) All individual life insurance and annuities contracts on a variable basis shall include the following:

1. A provision describing the periodic reports;

2. A provision specifying any rights for deferral. Payment of a death benefit in excess of any minimum guaranteed death benefits, of cash values, of partial withdrawals or of partial surrenders dependent upon the valuation of the separate account may be deferred for any period during which the New York Stock Exchange is closed for trading (except for normal holiday closings) or when the Securities and Exchange Commission has determined that a state of emergency exists which may make such payment

impractical. Any deferral of a minimum guaranteed death benefit for an individual variable life insurance contract shall comply with N.J.S.A. 17B:25–11; and

3. A provision describing any conditions for partial withdrawals, partial surrenders, loans, transfers and new deposits, including, but not limited to, restrictions on the amounts and timing of such transactions and the charging of any fees for such transactions. Any required minimum amount for a partial withdrawal, partial surrender, loan or transfer shall not exceed $1,000. The insurer shall not reserve the right to unilaterally change the contract provisions on minimum amount, timing or fees. However, the contract may set forth the most stringent limits and allow for the utilization of more favorable terms.

(b) In addition to the standards set forth at (a) above, all individual life insurance and annuities contracts on a variable basis shall comply with the requirements of N.J.S.A. 17B:28–1 et seq., and with all statutes and regulations applicable to non-variable life and annuity forms which are not inconsistent with the variable nature of the form.

(c) Individual life insurance and annuities contracts on a variable basis may include the following:

1. The contract may permit monies to be deposited into a general account fund. Such fund shall be subject to the Department's requirements for individual general account contracts, including, but not limited to, those set forth at N.J.A.C. 11:4–41 and 11:4–43.

2. The contract may contain variable wording, identified by the use of brackets, to describe the separate account funds and related charges. Variable wording may also be used in application forms which describe separate account funds.

Amended by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
In (a), deleted a former 1, recodified former 2 through 4 as 1 through 3, and substituted "$1,000" for "$500.00" at the end of the second sentence in the new 3.

11:4–44.4 Prohibited provisions

(a) The following restrictions shall apply to all individual life insurance and annuities contracts on a variable basis:

1. The insurer shall not reserve the right to unilaterally terminate or discontinue transfer privileges. Suspension of such privilege for a reasonable period is permitted if administered in a nondiscriminatory manner.

2. The insurer shall not require a signature guarantee of the owner for withdrawals, surrenders, loans or transfers.

3. The contract shall not refer to or rely upon the prospectus, but shall constitute the entire contract.

4. The insurer shall not reserve the right to terminate the contract for suspension in premium activity or for failure to maintain minimal amounts in the separate account, unless the reduction in values in the separate account is the direct result of partial withdrawal or surrender activity. However, an insurer may automatically transfer all monies to one fund or division of the separate account if the value of the separate account falls below a stated minimum. Any conditions for the transfer shall be described in the contract form. This paragraph shall not require an insurer to continue a scheduled, required premium contract beyond any grace period or nonforfeiture benefit provided by the contract or required by law.

11:4–44.5 Standards for individual market value adjusted annuities

(a) All individual market value adjusted annuities shall comply with the following standards:

1. The contract shall be identified and issued as a variable contract pursuant to N.J.S.A. 17B:28–1 et seq.;

2. The funds backing the contract shall be held in a separate account; and

3. The maturity value and cash value guarantees shall be obligations of the general account.

SUBCHAPTER 45. PERIODIC REPORTS

9. A description of all termination events, discontinuance triggers and options, notice requirements, corrective action procedures and all other contractual safeguards, including events that allow the insurer to terminate the contract immediately, and any special termination features of the contract whereby interest rate movements or participant withdrawal activity (or any combinations thereof) might terminate the insurer's contractual obligations;

10. A description of the procedures to be followed when a termination event occurs, but the insurer waives its right to terminate the contract;

11. A statement as to whether the assets in the segregated portfolio may be chargeable with liabilities unrelated to the assets of and services performed under the contract, together with a full explanation of the conditions under which such assets would be so chargeable; and

12. A description of the procedures to be followed in reporting in the Annual Statement for any risk charges.

(b) All data or information submitted to the Department under this section is confidential and shall not be disclosed by the Department to any person.

11:4–46.5 Contract requirements

(a) The contract shall include at least the following:

1. The permissible levels and timing of any new deposits to the segregated portfolio;

2. If the contract does not have a set maturity, settlement options at termination permitting the contractholder to receive the contract value record over time except in the case of unilateral termination;

3. For contracts having a crediting rate formula, the maximum permissible rate period between crediting rate recalculations;

4. A provision that the insurer shall have the right to perform audits and inspections of assets held in the segregated portfolio upon reasonable notice to the custodian;

5. A provision that the insurer shall receive prior notice of any change in custodian, investment manager or investment guidelines;

6. A clear description of the insurer's obligations under the contract, and the contingencies and circumstances under which payments shall be made by the insurer to the contractholder;

7. If a market value adjustment formula is to be used in calculating the effect on the contract value record of certain withdrawals from the segregated portfolio, a clear description of the types of withdrawals subject to market value adjustment;

8. The investment guidelines and any subsequent changes thereto attached to and made a part of the contract;

9. A provision permitting the insurer to unilaterally terminate the contract within 30 business days of the occurrence of any of the following events, except that (a)9i and ii below shall not apply in situations where the investment manager is controlled by the insurer pursuant to N.J.S.A. 17:27A–1:

i. The investment guidelines are changed without the advance consent of the insurer;

ii. The segregated portfolio is invested in a manner that does not comply with the investment guidelines;

iii. Investment discretion over the segregated portfolio is exercised by or granted to anyone other than the investment manager or successor thereof; or

iv. Any act of fraud, misrepresentation of material facts, deceit or any breach of the contract that materially and adversely affects or would have affected the intent, structure or risk profile of the contract;

10. The Department shall permit qualifiers such as "material" or "reasonable" to modify the termination provision referred to in (a)9 above and any other provisions in the contract so long as such qualifiers are adequately quantified in the plan of operation. The adequacy of any such terms shall be within the sole discretion of the Department; and

11. A waiver provision as follows:

No waiver of remedies by the insurer following the breach of any contractual provision or of the investment guidelines, or failure to enforce such provisions or guidelines by the insurer, shall be effective against any insurance commissioner with regulatory jurisdiction over this contract, including the domiciliary insurance commissioner, unless approved in writing by such domiciliary insurance commissioner and any other insurance commissioner with regulatory jurisdiction over this contract.

11:4–46.6 General requirements

(a) The insurer shall monitor the market value record for each contract. Upon each recalculation of the crediting rate, but no less frequently than quarterly, the insurer shall update the market value record to reflect the market value of the segregated portfolio.

(b) No contract shall be delivered or issued for delivery in this State unless the assets which it supports and for which a contract value is established are maintained in a segregated portfolio of a custodian.

(c) The investment guidelines shall be submitted to the insurer for underwriting review prior to the effective date of the contract.

(d) The investment guidelines shall permit investments of the segregated portfolio to be only in instruments for which market values are ascertainable pursuant to N.J.S.A. 17B:28–10.

(e) No contract shall obligate the insurer to purchase any assets at greater than market value or assets that would not be permitted investments pursuant to N.J.S.A. 17B:20–1 et seq.

(f) For group annuity contracts that make available to the contractholder the purchase of immediate or deferred annuities for the benefit of individual members of the group, no annuity shall be purchased without the delivery of the agreed consideration to the insurer for allocation to the insurer's general account or separate account as appropriate.

(g) In the case of unilateral termination of a contract pursuant to N.J.A.C. 11:4–46.5(a)9, the insurer shall refund any unearned risk premium or investment management fees, which shall terminate all future liability of the insurer or obligation to provide further benefits.

(h) In the case of an insurer's waiver of its right to terminate a contract when a termination event occurs, the Department shall require the insurer to submit a report describing the corrective action taken by the insurer.

(i) The insurer shall acknowledge in its submission that it shall maintain adequate reserves and collect adequate consideration for the cost of annuities purchased under contract option by transfer from the segregated portfolio.

11:4–46.7 Reserves

(a) Reserves shall be held by the insurer in the general account and shown on Exhibit 10 of the Annual Statement. The assets supporting those reserves, together with the assets in the segregated portfolio, shall be sufficient to mature the liabilities under moderately adverse conditions. Annual asset adequacy analysis shall be performed and reported on by the appointed actuary in the annual actuarial opinion submitted pursuant to the Standard Valuation Law. Asset adequacy analysis must consider the nature of the assets and liabilities, and the anticipated effect on contract value crediting rates of possible future changes in the interest rate environment.

(b) Following is one method of reserve calculation that may be set forth in the plan of operation. The Department shall also consider alternative methods that have been adopted by the NAIC or otherwise supported by detailed actuarial analysis.

1. Project future liability cash flows using the guaranteed rate(s) of interest. For contracts that do not have defined maturity structures (such as "evergreen" or constant duration contracts), use the maturity structure of the assets as a proxy for the maturity structure of the liabilities.

2. Discount the liability cash flows at spot rates of interest that do not exceed 105 percent of Treasury spot yields, and that are adjusted, if necessary, so that the internal rate of return on the liabilities does not exceed the internal rate of return on the assets.

3. Hold reserve equal to the excess, if any, of the sum of the discounted liability cash flows calculated in (b)2 above over the market value of the assets.

4. Hold as additional reserves whether reserves are indicated by asset adequacy analysis in the opinion of the appointed actuary.

11:4–46.8 Severability

If any provision of this subchapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the subchapter and the application of such provision(s) to other persons or circumstances shall not be affected thereby.

SUBCHAPTER 47. ACTUARIAL REQUIREMENTS FOR FLEXIBLE–FACTOR POLICY FORMS

11:4–47.1 Purpose and scope

(a) These rules set forth requirements regarding actuarial reports and memorandum which are to be developed in connection with flexible-factor life insurance forms for such forms to be filed by the Commissioner for use and delivery for use in this State pursuant to N.J.S.A. 17B:25–18, 17B:27–25, 17B:28–5 and P.L. 1995, c.73.

(b) These rules shall apply to any insurer seeking to deliver, or issue for delivery, a policy of life insurance under a flexible-factor form in this State.

11:4–47.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Department" means the New Jersey Department of Banking and Insurance.

"Flexible-factor form" means any life insurance policy, rider or endorsement, whether participating or nonparticipating, where the insurer reserves the right to modify (upward or downward) premiums, premium factors (interest, mortality, expenses) or benefits (death benefits, cash or loan values) on the basis of future anticipated or emerging experience.

"Insurer" means any person or persons, corporation, partnership, or company authorized or admitted to transact the business of life insurance in this State pursuant to Title 17B of the New Jersey Statutes.

"Minimum guarantee premium" means the minimum premium as established by the insurer to maintain coverage inforce and avoid lapse.

"Persistency bonus" means credit either to an explicit or implicit accumulation account which varies by duration in a manner which encourages or rewards persistency.

"Qualified actuary" means an individual who is a member in good standing of the American Academy of Actuaries and who is qualified to provide a Public Statement of Actuarial Opinion in accordance with standards set forth by the Actuarial Standards Board of the American Academy of Actuaries.

"Tiered factors" means accumulation account factors (such as interest rates, cost of insurance or mortality charges, and expense charges) which vary by a policy amount (such as accumulation account value, cash surrender value, face value, or net amount at risk), or which differ for various components (tiers) of a policy amount. Factors which vary by policy duration shall not be considered tiered factors, but may be considered persistency bonuses.

Amended by R.1997 d.444, effective October 20, 1997.
See: 29 N.J.R. 3409(a), 29 N.J.R. 4459(c).
Amended "Qualified actuary".
Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

11:4–47.3 General requirements

No form to which this subchapter applies may be delivered or issued for delivery in this State unless submitted to the Commissioner for review and filed by the Commissioner pursuant to all applicable law, including, but not limited to, N.J.A.C. 11:4–40.

11:4–47.4 Pricing assumptions—actuarial certification

(a) Each form submitted for filing shall be accompanied by a certification that the insurer has prepared an actuarial memorandum which specifies the formulas utilized in calculating premiums or flexible factors. The actuarial memorandum shall be available for review by the Department upon request. The actuarial memorandum shall be signed by a qualified actuary who shall indicate his or her professional qualifications and his or her relationship to the insurer (for example, company officer, consultant, etc.).

1. For purposes of (a) above, "formula" means the methodology used to set the premiums or factors. When asset shares or profit margins are used, the memorandum shall describe the method of calculating profits (that is, the accounting basis) and shall state the internal rate of return or other profit target. If the pricing target varies by pricing cell, the target shall be listed for a representative sample of pricing cells.

2. For policies to which N.J.A.C. 11:4–45 applies, the memorandum shall address the manner in which the cost of coverage is distributed among various factors (interest crediting rates, cost of insurance charges, expense charges, etc.), and the distribution of these factors over age and duration.

(b) The actuarial memorandum shall specify the projected assumptions as to investment earnings, mortality, persistency, and expense on which the initial premium or factor scale is based, together with comparable assumptions for maximum guaranteed premiums or factors set forth in the policy. The assumptions shall be set forth in sufficient detail to permit the Department to determine the profit factors implicit in the initial premium or factor tables. Assumptions that shall be indicated include, but are not limited to, reserve basis, if the pricing method includes profit; required surplus contributions treated as reserves; Federal income tax, if pricing is on an after-tax basis; and premium per unit of insurance, for flexible premium policies (that is, any policy where the policyholder may unilaterally change premium or choose not to pay premium).

1. The expense assumptions shall indicate whether expenses are on a marginal or a fully allocated basis. Expenses should be consistently allocated over the life of the block of business. For purposes of this section, "block of business" means all policies issued on the particular form by the insurer.

2. The profit factor(s) implicit in the initial premium or factor tables also shall be included. The profit factor may be expressed as either a rate of return, a present value of profits, or explicit margins associated within the premium or flexible factors.

(c) The actuarial memorandum shall include tables of all standard and preferred risk premiums or factors on both the initially intended non-guaranteed basis and the guaranteed basis. These tables are not required to include figures for substandard or rated policies.

1. All factors and premiums shall be provided in tabular form on both a current and guaranteed basis. For cost of insurance rates, a formula which reproduces the rates shall be deemed sufficient. Pricing factors (for example, expense charges) which are guaranteed and not subject to change should also be shown. The insurer shall distinguish between factors which are guaranteed

and not subject to change, and factors for which the current value is equal to the guaranteed value but which may be decreased, on a non-guaranteed basis, in the future.

2. The interest rate(s) used at the time of submission shall also be provided. Insurers shall advise the Department of any change in this (or any other factor) prior to the filing of the form by the Commissioner.

3. Minimum guarantee premiums for policies to which N.J.A.C. 11:4–45 applies, or critical values for tiered factors, persistency bonuses, or similar information shall be included.

4. Surrender charges shall be included if they are a flexible factor (subject to change) of if they are not included in conjunction with the memorandum required pursuant to N.J.A.C. 11:4–47.5.

(d) The insurer shall provide the Department with a statement of the intended conditions under which premiums or factors may be adjusted and the method by which these adjustments will be accomplished. This statement shall be construed as a statement of intention rather than a "guarantee" as to the insurer's future actions. The statement shall include the following:

1. A detailed explanation of the pricing methodology used to determine:

i. Initial premiums or premium factors; and

ii. The necessity and the amount of future adjustments to these premiums or premium factors;

2. A detailed description as to how current pricing assumptions and revised pricing assumptions shall be incorporated into the pricing methodology used to determine the necessity and the amount of future adjustments to premiums or premium factors; and

3. A detailed explanation of the magnitude of indicated changes (either as an amount or as a percentage) to current premiums or premium factors arising from the repricing of the form that would result in the implementation of these changes.

(e) All premium and factor formulas shall be approved by the insurer's board of directors, executive committee of the board, or an officer duly authorized by the board.

(f) The insurer shall indicate in its form submission that pricing assumptions for in-force policies will be reviewed whenever the premiums or factors for comparable new issues are changed, but in no event more often than once every policy year nor less often than once every five policy years. This review shall not be required during any period that premiums or factors are subject to an initial guarantee period.

(g) The actuarial memorandum shall contain a certification from the actuary that the assumptions are reasonable, and in the actuary's judgment, self-supporting and that the assumptions do not unfairly discriminate between new issues and in-force policies.

(h) In the case of non-participating policies, the insurer shall certify in the submission that future adjustments in premiums or factors will not be such as to distribute prior profits or to recoup past losses and that the changes will be based solely on future expectations as to investment earnings, mortality, persistency, and expenses.

(i) In the case of participating policies, the insurer shall certify in the submission that future adjustment in premiums or factors, other than dividends, will not be such as to distribute prior profit or to recoup past losses, and that the changes will be based on future expectations as to investment earnings, mortality, persistency, and expenses.

(j) Any adjustments in flexible factors or premiums made after the filing of the form, including changes in a non-guaranteed interest, shall be filed with the Department at least 60 days prior to implementation. The insurer may utilize the new premiums or factors provided the Commissioner has not disapproved such changes within the 60 day period.

1. The Commissioner shall waive the prior notice requirement set forth in (j) above in the case of interest rates when the insurer demonstrates to the Commissioner that credited rates are determined by a formula subject to (*l*) below.

2. For purposes of (j) above, "flexible factor" includes all factors which are redetermined on the basis of future experience (that is, current costs of insurance rates, interest rates and expenses charges for forms to which N.J.A.C. 11:4–45 applies, and current premiums for indeterminate premium forms).

3. Notification to the Department of any factor or premium change shall include the following information, without limitation:

i. An identifying form number(s) and filing date(s) of the form(s) to which the flexible factor change applies;

ii. An indication of the factor(s) which is being changed and the implementation date of such change, which shall be no sooner than 60 days after the notification of the change is filed with the Department;

iii. A specification of the categories (for example, face amount, date of issue, etc.) of new and in-force business to which the revised factors will apply. If the change is applicable only to new or only to in-force business, the submission should so indicate and include an explanation of the reasons for limited application of the change;

iv. The differences between the new factors and the last previously submitted factors for representative plans, ages and durations, and an indication whether the change represents an increase, decrease or no change from the prior filing, as well as a specification of the relative magnitude of any such change;

v. The rationale for the change, describing changes in experience or expectations leading to that change;

vi. A certification that an actuarial memorandum has been prepared, and is available for review by the Department upon request, which shall include: a certification by qualified actuary that the change does not increase the profit factor or, if changed, includes an explanation of the manner and reasons by which the profit factor is changed; specifies that the change does not unfairly discriminate between existing policies and new issues; and which otherwise satisfies the requirements set forth in (k) below; and

vii. A statement that the board of directors, executive committee, or officer duly authorized by the board has approved a flexible factor change as required by (e) above.

(k) The actuarial memorandum required pursuant to (j)3vi above shall contain a certification from the qualified actuary who prepared it that adjustments are such to retain or reduce the profit factor that was inherent in the rate formulas at issue. If, in the actuary's judgment, the profit factor for in-force policies should be increased, the actuarial memorandum shall provide all justifications for that increase.

1. The Commissioner shall disapprove changes in premiums or other factors which increase the profit factor for in-force business if he or she determines that the actuarial assumptions on which such change is based are unreasonable, not self-supporting, discriminate unfairly between new issues and in-force business, or are otherwise contrary to law.

2. Adjustments in premiums or factors which increase profits (before consideration of dividends) shall be acceptable if the Commissioner determines that future dividends will also be adjusted so that profit to the insurer, after dividends, is the same as was inherent in the rate formulas and anticipated dividends at issue.

(*l*) The Commissioner shall waive the requirement that the insurer provide 60 days' advance notice of changes in interest rates as set forth in (j) above, provided that the insurer include as part of its initial submission a statement of methodology for deriving the rate. The insurer shall provide 60 days' advance notice when the methodology is changed. The methodology shall tie the credited rate to a market (index) rate or earned rate on all or a segment of the insurer's portfolio, and the spread between this rate and the credited rate shall be fixed with a variation of no more than 25 basis points from the formula rate. Any interest rate methodology submitted pursuant to this subsection shall include, but not be limited to, the following:

1. The formula used to determine the credited rate;

2. If the formula involves the insurer's "earned rate," the following information:

i. The earned rate shall be identified as that earned by the general portfolio or by a specific block of assets. In the case of the latter, the specific assets shall be identified, either by listing each asset or by providing a summary which includes the amount and percentage of assets by issuer, duration to maturity, credit quality, payment structure, and call provisions;

ii. A description of the earnings of the assets used in determining the earned rate, including an indication of the manner by which capital gains (both realized and unrealized) and the earnings of subsidiaries are used in the calculation;

iii. An indication of whether the earned rate is net or gross of investment expenses, as well as a description of any provision for investment expenses implicit in the earned rate;

iv. The formula used to calculate the earned rate from investment earnings and asset values;

3. The frequency with which the credited rate is recalculated and redeclared; and

4. The frequency of compounding of the credited rate, and the earned or external index rate. Any implicit interest margin resulting from an inconsistency between the frequency of compounding of the earned or external rate and the credited rate shall be indicated.

(m) Any insurer seeking to utilize the alternative procedure set forth in (*l*) above shall provide to the Department the history of its interest rates upon request.

Amended by R.1997 d.444, effective October 20, 1997.
See: 29 N.J.R. 3409(a), 29 N.J.R. 4459(c).
In (d), added the third sentence; and inserted (d)1 through (d)3.

11:4–47.5 Nonforfeiture benefits—actuarial memorandum

(a) Each form submitted for filing shall be accompanied by a certification, signed by a qualified actuary, that the nonforfeiture benefits provided under the form are in compliance with N.J.S.A. 17B:25–19, and that an actuarial memorandum has been prepared and signed by a qualified actuary which demonstrates that such benefits are provided in compliance with N.J.S.A. 17B:25–19. The actuarial memorandum shall be available for review by the Department upon request.

(b) For forms where the principal variable is the insurer's right to change (either increase or decrease) premiums subject to a maximum premium amount, policy provisions relating to nonforfeiture shall satisfy the requirements set forth in N.J.S.A. 17B:25–19. For purposes of determining

compliance with this statute, "premiums specified in the policy" shall mean the initial scale, rather than the maximum scale, of guaranteed premiums, unless the latter would produce larger cash values. In this case, the minimum nonforfeiture benefits shall be based on the assumption that guaranteed maximum premiums shall apply wherever possible.

(c) For policies where cash values are determined retrospectively as an accumulation of gross premiums less expense charges, with interest increments and mortality decrements, the excess of expense charges in the first policy year over renewal expense charges may not be greater than the maximum initial expense allowance as set forth in N.J.S.A. 17B:25–19h(i). For purposes of determining the maximum initial expense allowance, the insurer at its option may adopt the method described in either (c)1 or 2 below. The certification accompanying each form submitted for filing shall specify which method has been used.

1. The plan of insurance may be considered to be either that which would result from an indefinite continuation of initial interest, mortality, and expense factors (that is, the apparent plan), or by the assumption that maximum guaranteed interest, mortality, and expense factors will apply at all durations (that is, the guaranteed plan). Except as provided in (c)1ii below, it shall be assumed that the premiums will continue to be paid at the initial level and frequency and the amount of death benefit will continue unchanged from the initial amount. The resulting plan of insurance shall be either an endowment to the age at which the cash value equals the initial insurance amount or term insurance to the age at which the cash value is exhausted. The maximum initial expense allowance shall be the smaller of the amounts so calculated for the apparent or the guaranteed plan of insurance.

i. The standards set forth in (c)1 above limit the excess first year expenses to an amount equal to the lesser of the maximum initial expense allowance for the apparent plan and the maximum initial expense allowance for the guaranteed plan.

ii. For the apparent plan and the guaranteed plan, insurers shall assume that the initial premium and initial death benefit continue unchanged, except that for policies having either a minimum guarantee provision or a minimum premium test provision as defined in N.J.A.C. 11:4–41.2 effective for a period of 11 or more years after issue (16 or more years for last survivor policies), it shall be assumed that the stipulated minimum premium is paid as required to avoid lapse in all years.

iii. For front end loaded policies without surrender charges, in order to satisfy the requirements set forth in (c)1 above, insurers may be required to express the front end load as a percentage of premium rather than as a flat amount. In the alternative, the insurer may be required to set forth a minimum first year premium which is sufficient to mature the policy.

2. The plan of insurance may be assumed to be whole life, subject to the following conditions:

i. A disclosure statement shall be provided to the prospective policyowner at the time of application and shall be printed prominently (that is, on or in close proximity to the initial schedule page and in bolder or larger type) on the schedule page of the policy form for any policy for which the initial premium is lower than that premium which, when paid in level amounts at the initial frequency, would provide coverage to the earlier of policy maturity or age 100, assuming indefinite continuation of initial interest, mortality and expense factors. For policies having either a minimum guarantee provision or a minimum premium test provision effective for a period of 11 or more years after issue (16 or more years for last survivor policies), the initial premium shall be deemed to be the stipulated minimum premium. The disclosure statement shall state:

> Assuming current interest, mortality and expense factors continue indefinitely and a premium equal to the initial premium (or minimum premium, if applicable) is paid (insert premium mode selected by owner), this policy will provide coverage for xx years; based on guaranteed interest, mortality and expense factors, this policy will provide coverage for yy years. Other policy forms designed specifically to provide term insurance may offer similar benefits for such periods at a lower cost or with higher cash surrender values. You should consider whether this policy or such alternative policy is right for you.

ii. Regardless of initial premium, no disclosure statement shall be required for last survivor policies with a face amount greater than or equal to $500,000.

(d) All policy forms may incorporate surrender charges of specified amounts at specified durations, provided that the resulting cash values are at least as large as those developed under (c) above assuming a maximum initial expense allowance and no surrender charges. For purposes of this subsection, "specified" surrender charges means that the policyholder can determine at issue the exact amount of surrender charge applicable at any future time. Surrender charges provided by a table included in the policy or surrender charges as a percentage of initial premiums or death benefits shall be specified, but surrender charges as a percentage of variable future premiums, values or benefits are not specified.

1. The scale of surrender charges shall be such as to satisfy the tests regarding detection and avoidance of discontinuities in life insurance policies set forth in Exhibit 1 in the Appendix to this subchapter, incorporated herein by reference. The actuarial memorandum prepared pursuant to (a) above shall include a certification from a qualified actuary that surrender charges, if any, are in compliance with these tests for representative issue ages and premium/benefit arrangements on an "apparent plan" basis or, in the alternative, provide justification for instances where the tests may not be satisfied.

2. The insurer may satisfy the requirements set forth in (d) above by demonstrating that surrender charges are less than the unamortized unused initial first year expense allowance. The initial expense allowance shall be derived pursuant to (c) above. Further, the expense allowance shall be amortized over the period for which coverage was purchased.

(e) In order to demonstrate compliance with the requirements set forth in (c) and (d) above, the actuarial memorandum prepared pursuant to (a) above shall contain the following:

1. A description of the calculation of the maximum initial expense allowance, including a specific reference to the guaranteed plan purchased by the initial premium;

2. A demonstration, either algebraically or by comparing the maximum initial expense allowance to the excess first year expenses for all ages and classes, that the requirements set forth in (c) are satisfied; and

3. If there are surrender charges, a comparison, either tabular or by algebraic formula, of surrender charges to unused unamortized expense allowance at all durations.

(f) In addition to surrender charges as permitted pursuant to (d) above, a policy may contain provision for surrender charges in the form of withholding portions of credited excess interest or similarly calculated percentages of accumulated amounts. This type of surrender charge shall be considered a protection against possible asset liquidation loss at time of cash value payment, and the insurer shall state in the actuarial memorandum prepared pursuant to (a) above the circumstances under which such a surrender charge would be imposed. If the charge is to be imposed unconditionally, the minimum value test required pursuant to (d) above shall include the unspecified surrender charge in all calculations, and the insurer, in policy summaries and sales illustrations, may not display any accumulation amounts greater than the cash values assuming imposition of all surrender charges.

(g) Any insurer asserting that the form submitted for filing is not subject to N.J.S.A. 17B:25–19 shall file a certification signed by a qualified actuary with the form submission that:

1. Sets forth in detail the basis upon which the insurer determined that the particular form is not subject to N.J.S.A. 17B:25–19; and

2. States that an actuarial memorandum has been prepared and signed by a qualified actuary which demonstrates that the form is exempt from N.J.S.A. 17B:25–19. The actuarial memorandum shall be available for review by the Department upon request. This certification shall include:

i. A citation of the specific exemption from N.J.S.A. 17B:25–19 asserted by the insurer;

ii. An explanation as to why the insurer believes the exemption applies, and if the exemption cited is based upon the seventh bulleted item (the "de minimis" test) of N.J.S.A. 17B:25–191; and

iii. A statement as to which issue ages were tested to determine qualification for this exemption.

Amended by R.1997 d.444, effective October 20, 1997.
See: 29 N.J.R. 3409(a), 29 N.J.R. 4459(c).
Rewrote (c) as (c) and (c)1; recodified (c)1 through (c)3 as (c)1i through (c)1iii; inserted new (c)2; in (g), substituted "certification" for "memorandum", and deleted "company officer or" preceding "qualified actuary"; and added (g)1 and (g)2.

11:4–47.6 Recordkeeping

Any actuarial memorandum prepared as required by this subchapter shall be retained by the insurer, and submitted to the Department upon request, until such time as the policy form is no longer being issued or delivered to persons residing in this State.

11:4–47.7 Penalties

Failure to comply with this subchapter shall result in the disapproval of any flexible-factor form for delivery in this State, as well as imposition of any other penalties as may be authorized by law.

APPENDIX

EXHIBIT 1

DETECTION AND AVOIDANCE OF DISCONTINUITIES IN LIFE INSURANCE POLICIES

Detecting Possible Manipulation: The Mechanical Approach

Manipulation is manifested in irregularities in the otherwise smooth progression of the net result of offsetting the dividends and the changes each year in cash values against the annual premiums, i.e., irregularities in the annual policy cost from the policyowner's viewpoint. We have examined several ways of testing for such irregularities and of arriving at limits beyond which they may be cause for inquiry by the regulators.

The method that we regard as most likely to work satisfactorily is described technically as follows:

1. The test measures irregularities in policy values which are identified by the yearly prices of protection. Yearly prices are based on premiums, illustrated dividends, cash surrender values, death benefits, and an imputed interest rate of five percent.

2. The test is applied to the sum of the squares of the second backward differences in yearly prices. This measure is obtained as follows: First, the differences between successive changes in yearly prices are calculated. These "second differences" are then squared to avoid the offset-

ting effect of positive and negative values. Finally, the squared second differences are added for policy years 8–23. Because the test omits from the calculation yearly prices prior to year 6, it will not detect irregularities in yearly prices during the first five policy years. The use of the mechanical approach in early policy years is burdened by variations in expense amortization and in early year cash surrender values. It was the judgment of the committee that incorporation of yearly prices beyond policy year 23 is currently unnecessary.

3. For the time being, we recommend a set of limits be used to separate whole life policies that are to be subjected to regulatory consideration which produces a manageable volume of identified policies. The upper limits of the test measure we recommend for acceptable policies are:

Issue Age	Test Limit
25 and under	300
35	500
45 and over	600

(Limits for other ages to be obtained by interpolation.) These limits apply to all policy sizes tested and isolated five percent of all of the policies in our test sample.

Example 1

The first example is a participating whole life policy issued to a male aged 35. The calculation is made on a per $1,000 basis:

Policy Year	Guaranteed Cash Value	Illustrated Annual Dividend	Illustrated Terminal Dividend	Premium
1	0.0	0.0	0.00	21.40
2	8.77	2.40	0.00	21.40
3	31.27	2.65	0.00	21.40
4	54.28	2.90	0.00	21.40
5	77.82	3.16	0.00	21.40
6	94.24	3.16	0.00	21.40
7	110.93	3.16	0.00	21.40
8	127.88	3.41	0.00	21.40
9	145.09	3.41	0.00	21.40
10	162.54	3.66	8.00	21.40
11	180.22	4.16	8.00	21.40
12	198.11	4.67	8.00	21.40
13	216.20	5.17	8.00	21.40
14	234.46	5.68	8.00	21.40
15	252.88	6.18	8.00	21.40
16	271.43	6.69	8.00	21.40
17	290.10	7.19	8.00	21.40
18	308.87	7.95	8.00	21.40
19	327.73	8.46	8.00	21.40
20	346.65	9.47	25.00	21.40
21	365.62	10.48	25.00	21.40
22	384.60	11.49	25.00	21.40
23	403.57	12.50	25.00	21.40
24	422.50	13.51	25.00	21.40
25	441.37	14.52	25.00	21.40
26	460.14	15.53	25.00	21.40
27	478.78	16.54	25.00	21.40
28	497.28	17.55	25.00	21.40
29	515.60	18.56	25.00	21.40
30	533.70	19.57	25.00	21.40

The yearly prices, (backward) second differences in yearly prices, and their squares for this policy are:

Policy Year	(1) Yearly Price	(2) Second Difference in Yearly Price	(3) Second Difference Squared
1	21.40	—	NA
2	10.76	—	NA
3	–2.13	–2.25	NA
4	–1.79	13.23	NA
5	–1.44	.01	NA
6	6.46	7.55	NA
7	6.98	–7.38	NA
8	7.29	–.21	.0441
9	7.85	.25	.0625
10	.59	–7.82	61.1524
11	8.72	15.39	236.8521
12	8.88	–7.97	63.5209
13	9.06	.02	.0004
14	9.28	.04	.0016
15	9.52	.02	.0004
16	9.78	.02	.0004
17	10.08	.04	.0016
18	10.15	–.23	.0529
19	10.47	.25	.0625
20	–5.84	–16.63	276.5569
21	11.05	33.20	1,102.2400
22	10.98	–16.96	287.6416
23	10.93	.02	.0004
24	10.91	.03	NA
25	10.91	.02	NA
26	10.94	.03	NA
27	11.00	.03	NA
28	11.06	.00	NA
29	11.15	.03	NA
30	11.27	.03	NA

The column (1) yearly prices are the values of the Yearly Price of Death Benefits per (1000).

Column (2) is calculated by subtracting the change observed in the yearly price in year t–1 from the change observed in the yearly price in year t. For example, the second difference of –16.63 in year 20 is calculated:

$$\begin{aligned} -16.63 &— (-5.84–10.47) - (10.47–10.15) \\ &— -16.31–.32 \\ &— -16.63 \end{aligned}$$

Column (3), second difference squared, is the square of the figure in column (2). The sum of the squared second differences between years 8 and 23 is 2028. This sum exceeds by 1528 the test limit for issue age 35 of 500. A company actuary would be required to justify the abrupt discontinuities in yearly prices in policy years 10 and 20. These discontinuities are attributable to the unusual annual dividend scale and terminal dividend scale.