

CHAPTER 4

ACTUARIAL SERVICES

Authority

N.J.S.A. 17:1C-6e.

Source and Effective Date

R.1996 d.4, effective November 30, 1995.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

Executive Order No. 66(1978) Expiration Date

Chapter 4, Actuarial Services, expires on November 30, 2000.

Chapter Historical Note

Chapter 4, Actuarial Services, was filed and became effective prior to September 1, 1969.

1972 Revisions: Subchapter 2, Replacement of Life Insurance Policy, was originally filed and became effective April 1, 1972 as R.1972 d.21.

1973 Revisions: Subchapter 7, Procedure for the Regulation of Consent to Higher Rate Filings, was filed March 23, 1973 as R.1973 d.82, effective April 15, 1973, for automobile insurance; and effective July 1, 1973, for all other lines of insurance. See: 4 N.J.R. 220(a), 5 N.J.R. 113(b).

1974 Revisions: Subchapter 8, Charitable Annuities, was adopted as new rules by R.1974 d.258, effective September 20, 1974. See: 6 N.J.R. 315(a), 6 N.J.R. 399(c).

1976 Revisions: Subchapter 11, Life Insurance Solicitation, was adopted as new rules by R.1976 d.329, effective October 18, 1976. See: 8 N.J.R. 336(a), 8 N.J.R. 517(a).

1977 Revisions: Subchapter 13, Group Student Health Insurance, was adopted as new rules by R.1977 d.309, effective August 22, 1977. See: 9 N.J.R. 343(c), 9 N.J.R. 438(d). Subchapter 14, Home Health Care Insurance Coverage, was adopted as new rules by R.1977 d.476, effective December 15, 1977. See: 9 N.J.R. 479(f), 10 N.J.R. 16(d).

1978 Revisions: Subchapter 15, Alcoholism Benefits, was adopted as new rules by R.1978 d.165, effective May 22, 1978. See: 10 N.J.R. 162(a), 10 N.J.R. 257(a).

1979 Revisions: Subchapter 20, Blindness; Partial Blindness or other Physical or Mental Impairments; Unfair Discrimination, was adopted as new rules by R.1979 d.434, effective December 6, 1979. See: 11 N.J.R. 384(a), 11 N.J.R. 627(f).

1980 Revisions: Subchapter 16, Minimum Standards for Individual Health Insurance; Subchapter 17, Health Insurance Solicitation; and Subchapter 18, Individual Health Insurance Rate Filings, were adopted as new rules by R.1980 d.176, effective April 21, 1980. See: 11 N.J.R. 348(a), 12 N.J.R. 342(c). On June 12, 1980, the New Jersey Legislature adopted Senate Concurrent Resolution 110 disapproving Subchapters 16, 17 and 18 pursuant to N.J.S.A. 17B:26-45d. On August 5, 1980, the Department of Insurance readopted Subchapters 16, 17 and 18 in their entirety, with amendments to N.J.A.C. 11:4-16.8(b), 11:4-17.6 and 11:4-17.7, as R.1980 d.343. See: 12 N.J.R. 420(c), 12 N.J.R. 538(b). Subchapter 21, Limited Death Benefits Forms, was adopted as new rules by R.1980 d.265, effective June 18, 1980. See: 12 N.J.R. 279(b), 12 N.J.R. 423(c).

1982 Revisions: The existing text of Subchapter 2, Replacement of Life Insurance Policy, was repealed and new rules were adopted as R.1982 d.16, effective February 1, 1982 (operative June 1, 1982). See: 13 N.J.R. 18(e), 14 N.J.R. 158(d).

1983 Revisions: Pursuant to Executive Order No. 66(1978), Subchapter 15, Alcoholism Benefits, expired on May 22, 1983.

1984 Revisions: Subchapter 22, Individual Life Insurance: Use of Gender Blended Mortality Tables, was adopted as new rules by R.1984 d.478, effective November 5, 1984. See: 16 N.J.R. 1452(a), 16 N.J.R. 3040(a). Pursuant to Executive Order No. 66(1978), Subchapter 6, Reserve Standards for Individual Health Insurance Policies, was readopted as R.1984 d.512, effective November 5, 1984. See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

1985 Revisions: Subchapter 23, Medicare Supplement Policies and Contracts, was adopted as new rules by R.1985 d.70, effective February 19, 1985 (operative June 19, 1985). See: 16 N.J.R. 2945(a), 17 N.J.R. 460(a). Pursuant to Executive Order No. 66(1978), Subchapter 20 was readopted as R.1985 d.161, effective April 1, 1985. See: 17 N.J.R. 168(a), 17 N.J.R. 820(a). Pursuant to Executive Order No. 66(1978), Subchapters 16, 17 and 18 were readopted as R.1985 d.221, effective April 15, 1985. See: 17 N.J.R. 554(a), 17 N.J.R. 1129(a). Subchapter 21 was readopted as R.1985 d.325, effective June 3, 1985. See: 17 N.J.R. 891(a), 17 N.J.R. 1660(a). Subchapter 24, Smoker and Non-smoker Mortality Tables, was adopted as new rules by R.1985 d.617, effective December 2, 1985. See: 17 N.J.R. 2348(a), 17 N.J.R. 2907(a). Subchapter 26, Annuity Mortality Tables, was adopted as new rules by R.1985 d.616, effective December 2, 1985. See: 17 N.J.R. 2349(a), 17 N.J.R. 290(a).

1986 Revisions: Subchapter 15, Alcoholism Benefits, was adopted as new rules by R.1986 d.228, effective June 16, 1986. See: 18 N.J.R. 607(a), 18 N.J.R. 1302(a).

1988 Revisions: Subchapter 19, Optional Coverage for Pregnancy and Childbirth Benefits, was adopted as new rules by R.1988 d.455, effective September 19, 1988. See: 20 N.J.R. 43(a), 20 N.J.R. 2377(c). Subchapter 28, Group Coordination of Benefits, was adopted as new rules by R.1988 d.499, effective October 17, 1988. See: 20 N.J.R. 1773(b), 20 N.J.R. 2581(a).

1989 Revisions: Subchapter 29, Homeowners Comparison Survey, was adopted as new rules by R.1989 d.50, effective January 17, 1989. See: 20 N.J.R. 2181(a), 21 N.J.R. 164(a). Subchapter 31, Term Life Insurance Comparison Survey, was adopted as new rules by R.1989 d.122, effective February 21, 1989. See: 20 N.J.R. 2990(a), 21 N.J.R. 566(a). Subchapter 32, Health Service Corporation Notice of Increased Rates, was adopted as R.1989 d.522, effective October 2, 1989. See: 21 N.J.R. 973(b), 21 N.J.R. 3173(c). Subchapter 33, Excess Interest Reserve Adjustment, was adopted as new rules by R.1989 d.523, effective October 2, 1989. See: 21 N.J.R. 1308(a), 21 N.J.R. 3175(c). Subchapter 34, Long-Term Care Insurance, was adopted as new rules by R.1989 d.571, effective November 6, 1989. See: 21 N.J.R. 1964(a), 21 N.J.R. 3465(a).

1990 Revisions: Subchapter 25 regarding Medicare supplement interim standards, was adopted as new rules by R.1990 d.214, effective April 16, 1990. See: 22 N.J.R. 320(a), 22 N.J.R. 1266(b).

1991 Revisions: Pursuant to Executive Order No. 66(1978), Chapter 4 was readopted as R.1991 d.3, effective November 30, 1990. As part of R.1991 d.3, Subchapter 1, Contracts on a Variable Basis, was repealed effective January 7, 1991. See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a). Subchapter 35, Annual Medicare Supplement Policy Survey, was adopted as new rules by R.1991 d.122, effective March 4, 1991. See: 22 N.J.R. 1226(b), 23 N.J.R. 698(a). Subchapter 23, Medicare Supplement Policies and Contracts, was changed to Minimum Standards for Medicare Supplement Coverage by R.1991 d.345, effective July 1, 1991. See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a). Notice of Action on Petition for Rulemaking: Regulation of Authority on Group Health Insurance Contracts. See: 23 N.J.R. 2546(c). Denial of Petition for Rulemaking: Declaration of Authority to Regulate Group Health Insurance Contracts. See: 23 N.J.R. 3827(a).

1993 Revisions: Subchapter 25 was repealed by R.1993 d.26, effective January 4, 1993. See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

1994 Revisions: Subchapter 37, Selective Contracting Arrangements of Insurers, was adopted as new rules by R.1994 d.45, effective January 18, 1994. See: 25 N.J.R. 4554(b), 26 N.J.R. 381(a).

1995 Revisions: Subchapter 9, Personal Lines Insurance: Prospective Loss Costs Filing Procedures, was adopted as new rules by R.1995 d.406, effective August 7, 1995. See: 27 N.J.R. 1356(b), 27 N.J.R. 2931(a). Subchapter 30, Accelerated Death Benefits, was adopted as new rules by R.1995 d.521, effective September 18, 1995. See: 27 N.J.R. 2046(a), 27 N.J.R. 3613(c). Subchapter 40, Life/Health/Annuity Forms, was adopted as new rules by R.1995 d.569, effective November 6, 1995. See: 27 N.J.R. 2857(a), 27 N.J.R. 2867(a), 27 N.J.R. 4317(a). An administrative correction, published November 20, 1995, restored comments to the notice of adoption of Subchapter 40 which were inadvertently omitted. See: 27 N.J.R. 4728(a).

1996 Revisions: Pursuant to Executive Order No. 66(1978), Chapter 4 was readopted as R.1996 d.4, effective November 30, 1995. As part of R.1996 d.4, Subchapter 5, Amendment to Instructions to Life and Accident and Health Annual Statement Blank; Subchapter 10, Expense Experience; Subchapter 32, Health Service Corporation Notice of Increased Rates; Subchapter 35, Annual Medicare Supplement Policy Survey; and Exhibits A and B of the Appendix to Subchapters 16 and 23 were repealed effective January 2, 1996. See: Source and Effective Date. See, also, section annotations.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. (RESERVED)

SUBCHAPTER 2. REPLACEMENT OF LIFE INSURANCE POLICY

- 11:4-2.1 Purpose
- 11:4-2.2 Definitions
- 11:4-2.3 Exemptions
- 11:4-2.4 Duties of agent
- 11:4-2.5 Duties of replacing insurers
- 11:4-2.6 Duties of insurers with respect to direct-response sales
- 11:4-2.7 Duties of the existing insurer
- 11:4-2.8 Penalties
- 11:4-2.9 Separability

SUBCHAPTER 3. COUPON POLICIES AND POLICIES CONTAINING GUARANTEED ANNUAL ENDOWMENT BENEFITS

- 11:4-3.1 Payments
- 11:4-3.2 Gross premium shown
- 11:4-3.3 Gross premium regarding additional insurance
- 11:4-3.4 Coupons
- 11:4-3.5 Guaranteed annual endowments
- 11:4-3.6 Severability
- 11:4-3.7 Effective date

SUBCHAPTER 4. PASSBOOKS USED IN CONNECTION WITH COUPON POLICIES OR POLICIES CONTAINING GUARANTEED ANNUAL ENDOWMENT BENEFITS

- 11:4-4.1 General provisions
- 11:4-4.2 Unfair practice
- 11:4-4.3 Scope
- 11:4-4.4 Severability
- 11:4-4.5 Effective date

SUBCHAPTER 5. (RESERVED)

SUBCHAPTER 6. RESERVE STANDARDS FOR INDIVIDUAL HEALTH INSURANCE POLICIES

- 11:4-6.1 Purpose
- 11:4-6.2 Scope
- 11:4-6.3 Definitions
- 11:4-6.4 Active life reserve—general
- 11:4-6.5 Types of individual health insurance policies

- 11:4-6.6 Reserve standards for policies of Type A, B or C
- 11:4-6.7 Reserve standards for policy Type D
- 11:4-6.8 Claim reserves; present value of amounts not yet due on claims
- 11:4-6.9 Loss of time policies
- 11:4-6.10 Tabular reserves; deficiency reserve requirement
- 11:4-6.11 Commissioner's Disability Table
- 11:4-6.12 Active life reserve factors; elimination period
- 11:4-6.13 Policy applicability
- 11:4-6.14 Severability

SUBCHAPTER 7. PROCEDURE FOR THE REGULATION OF CONSENT TO HIGHER RATE FILINGS

- 11:4-7.1 Filing requirements
- 11:4-7.2 Premium charges
- 11:4-7.3 Approval of applications

SUBCHAPTER 8. CHARITABLE ANNUITIES

- 11:4-8.1 Purpose
- 11:4-8.2 Forms of agreement
- 11:4-8.3 Annuity rates
- 11:4-8.4 Surplus and reserves
- 11:4-8.5 Compliance with investment requirements
- 11:4-8.6 Annual report
- 11:4-8.7 Special permit
- 11:4-8.8 Separability of provisions
- 11:4-8.9 Penalties

SUBCHAPTER 9. PERSONAL LINES INSURANCE: PROSPECTIVE LOSS COSTS FILING PROCEDURES

- 11:4-9.1 Purpose and scope
- 11:4-9.2 Definitions
- 11:4-9.3 Prospective loss cost filing requirements for rating organizations
- 11:4-9.4 Prospective loss costs filing requirements for insurers
- 11:4-9.5 Penalties

APPENDIX A

APPENDIX B

SUBCHAPTER 10. (RESERVED)

SUBCHAPTER 11. LIFE INSURANCE SOLICITATION

- 11:4-11.1 Authority
- 11:4-11.2 Purpose
- 11:4-11.3 Scope
- 11:4-11.4 Definitions
- 11:4-11.5 Disclosure requirements
- 11:4-11.6 General provisions
- 11:4-11.7 Failure to comply
- 11:4-11.8 Effective date

APPENDIX. LIFE INSURANCE BUYER'S GUIDE

SUBCHAPTER 12. STUDENT LIFE INSURANCE

- 11:4-12.1 Student life insurance solicitation

SUBCHAPTER 13. GROUP STUDENT HEALTH INSURANCE

- 11:4-13.1 Scope
- 11:4-13.2 Definitions
- 11:4-13.3 Prohibited provisions

SUBCHAPTER 14. HOME HEALTH CARE INSURANCE COVERAGE

- 11:4-14.1 Scope
- 11:4-14.2 Definitions
- 11:4-14.3 Home health care benefits required

- 11:4-14.4 Exclusions
- 11:4-14.5 Effective date

SUBCHAPTER 15. ALCOHOLISM BENEFITS

- 11:4-15.1 Scope
- 11:4-15.2 Benefits
- 11:4-15.3 Exclusions

SUBCHAPTER 16. MINIMUM STANDARDS FOR INDIVIDUAL HEALTH INSURANCE

- 11:4-16.1 Purpose
- 11:4-16.2 Applicability and scope
- 11:4-16.3 Effective date
- 11:4-16.4 Policy definitions
- 11:4-16.5 Prohibited policy provisions
- 11:4-16.6 Minimum standards for benefits
- 11:4-16.7 Application forms
- 11:4-16.8 Required disclosure provisions
- 11:4-16.9 Forms submission requirements
- 11:4-16.10 Separability
- 11:4-16.11 Penalties

APPENDIX A**SUBCHAPTER 17. HEALTH INSURANCE SOLICITATION**

- 11:4-17.1 Purpose
- 11:4-17.2 Applicability and scope
- 11:4-17.3 Definitions
- 11:4-17.4 Unfair and deceptive acts
- 11:4-17.5 Replacement
- 11:4-17.6 Complaint record to be maintained
- 11:4-17.7 Penalties
- 11:4-17.8 Separability
- 11:4-17.9 Effective date

SUBCHAPTER 18. INDIVIDUAL HEALTH INSURANCE RATE FILINGS

- 11:4-18.1 Purpose
- 11:4-18.2 Applicability and scope
- 11:4-18.3 Definitions
- 11:4-18.4 Rate submission requirements
- 11:4-18.5 Loss ratio standards
- 11:4-18.6 Annual review of calendar year experience data on filed individual health insurance policy forms
- 11:4-18.7 Rate manual
- 11:4-18.8 Separability
- 11:4-18.9 Penalties
- 11:4-18.10 Compliance

SUBCHAPTER 19. OPTIONAL COVERAGE FOR PREGNANCY AND CHILDBIRTH BENEFITS

- 11:4-19.1 Purpose
- 11:4-19.2 Scope
- 11:4-19.3 Second surgical opinions
- 11:4-19.4 Maternity benefits option

SUBCHAPTER 20. BLINDNESS; PARTIAL BLINDNESS OR OTHER PHYSICAL OR MENTAL IMPAIRMENT; UNFAIR DISCRIMINATION

- 11:4-20.1 Purpose
- 11:4-20.2 Unfair discriminatory acts or practices

SUBCHAPTER 21. LIMITED DEATH BENEFITS FORMS

- 11:4-21.1 Purpose; scope
- 11:4-21.2 Definitions
- 11:4-21.3 General requirements
- 11:4-21.4 Severability

SUBCHAPTER 22. INDIVIDUAL LIFE INSURANCE: USE OF GENDER BLENDED MORTALITY TABLES

- 11:4-22.1 Purpose
- 11:4-22.2 Definitions
- 11:4-22.3 Construction of gender blended tables for use in the determination of minimum nonforfeiture benefits and minimum reserves
- 11:4-22.4 Construction of Gender Blended Smoker and Nonsmoker Mortality Tables for use in the determination of minimum nonforfeiture benefits and minimum reserves
- 11:4-22.5 Use of gender blended mortality tables in the non-Norris market
- 11:4-22.6 Effect on previously filed forms
- 11:4-22.7 Unfair discrimination
- 11:4-22.8 Separability

APPENDIX A. MORTALITY TABLES**APPENDIX B. 1980 CSO-SA SMOKER TABLES****SUBCHAPTER 23. MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT COVERAGE**

- 11:4-23.1 Purpose
- 11:4-23.2 Applicability and scope
- 11:4-23.3 Definitions
- 11:4-23.4 Policy definitions and terms
- 11:4-23.5 Policy provisions
- 11:4-23.6 General minimum benefit standards
- 11:4-23.7 Minimum benefits for policies and certificates delivered or issued for delivery prior to January 4, 1993
- 11:4-23.8 Minimum benefit standards for policies and certificates delivered or issued for delivery on or after January 4, 1993
- 11:4-23.9 Open enrollment
- 11:4-23.10 Standards for claims payment
- 11:4-23.11 Loss ratio standards, annual filing of premium rates and refund or credit calculation
- 11:4-23.12 Guaranteed issue for eligible persons
- 11:4-23.13 Filing requirements for policies, certificates and premium rates
- 11:4-23.14 Compensation arrangements
- 11:4-23.15 Required disclosure provisions
- 11:4-23.16 Requirements for application forms and replacement coverage
- 11:4-23.17 Filing requirements for advertising
- 11:4-23.18 Standards for marketing
- 11:4-23.19 Appropriateness of recommended purchase and excessive coverage
- 11:4-23.20 Reporting of multiple policies
- 11:4-23.21 Addresses for submission for filing
- 11:4-23.22 Penalties
- 11:4-23.23 Severability

APPENDIX TO SUBCHAPTERS 16 AND 23**EXHIBITS A AND B (RESERVED)**

EXHIBIT C
EXHIBIT D
EXHIBIT E
EXHIBIT F
EXHIBIT G
EXHIBIT H

SUBCHAPTER 23A. MEDICARE SUPPLEMENT—UNDER 50 COVERAGE

- 11:4-23A.1 Purpose and scope
- 11:4-23A.2 Definitions
- 11:4-23A.3 Creation of Medicare Supplement—Under 50 Coverage Plan
- 11:4-23A.4 Governing Board
- 11:4-23A.5 Plan of operation
- 11:4-23A.6 Open enrollment

- 11:4-23A.7 Rates
- 11:4-23A.8 Reports
- 11:4-23A.9 Equitable sharing of losses and audit
- 11:4-23A.10 Assessments
- 11:4-23A.11 Appeal to the Commissioner
- 11:4-23A.12 Assessment relief requests

SUBCHAPTER 23B. MEDICARE SUPPLEMENT—AGE 50 THROUGH 64 COVERAGE

- 11:4-23B.1 Purpose and scope
- 11:4-23B.2 Definitions
- 11:4-23B.3 Open enrollment
- 11:4-23B.4 Rates

SUBCHAPTER 24. SMOKER AND NONSMOKER MORTALITY TABLES

- 11:4-24.1 Purpose
- 11:4-24.2 Definitions
- 11:4-24.3 Smoker and nonsmoker mortality tables
- 11:4-24.4 Juvenile insureds
- 11:4-24.5 Separability

SUBCHAPTER 25. FUNERAL INSURANCE POLICIES

- 11:4-25.1 Purpose; scope
- 11:4-25.2 Definitions
- 11:4-25.3 Forms submission requirements
- 11:4-25.4 Disclosure requirements
- 11:4-25.5 Loss ratio standard
- 11:4-25.6 Severability
- 11:4-25.7 Penalties

SUBCHAPTER 26. ANNUITY MORTALITY TABLES

- 11:4-26.1 Purpose
- 11:4-26.2 Definitions
- 11:4-26.3 Individual annuity or pure endowment contracts
- 11:4-26.4 Group annuity or pure endowment contracts
- 11:4-26.5 Separability

SUBCHAPTER 27. REPORTING A LIQUOR LAW LIABILITY LOSS EXPERIENCE STATISTICS

- 11:4-27.1 Purpose
- 11:4-27.2 Scope
- 11:4-27.3 Definitions
- 11:4-27.4 Schedule and procedures for reporting liquor law liability loss experience statistics
- 11:4-27.5 Penalties

APPENDIX A. RISKS WITH ALCOHOL BREATH ANALYZER

APPENDIX B. RISKS WITHOUT ALCOHOL BREATH ANALYZER

SUBCHAPTER 28. GROUP COORDINATION OF BENEFITS

- 11:4-28.1 Purpose; applicability
- 11:4-28.2 Definitions
- 11:4-28.3 Coordination permissive
- 11:4-28.4 Model COB contract provision
- 11:4-28.5 Prohibited coordination; benefit design
- 11:4-28.6 Rules for coordination of benefits
- 11:4-28.7 Procedure to be followed by secondary plan to reduce benefits
- 11:4-28.8 Reasonable monetary value of services
- 11:4-28.9 Excess and other nonconforming provisions
- 11:4-28.10 Substitute terminology in contracts
- 11:4-28.11 Compliance
- 11:4-28.12 Severability

APPENDIX A. MODEL COB PROVISIONS

SUBCHAPTER 29. HOMEOWNERS COMPARISON SURVEY

- 11:4-29.1 Purpose and scope
- 11:4-29.2 Definitions
- 11:4-29.3 Coverage option survey requirements

APPENDIX A

APPENDIX B

APPENDIX C

SUBCHAPTER 30. ACCELERATED DEATH BENEFITS

- 11:4-30.1 Purpose
- 11:4-30.2 Application and scope
- 11:4-30.3 Definitions
- 11:4-30.4 Permitted forms of accelerated death benefit provisions
- 11:4-30.5 Partial surrender
- 11:4-30.6 Lien
- 11:4-30.7 Payment options
- 11:4-30.8 Terms of accelerated death benefit contract provisions
- 11:4-30.9 Exercise of the option to accelerate the payment of death benefits
- 11:4-30.10 Form submission requirements
- 11:4-30.11 Illustrations
- 11:4-30.12 Discrimination
- 11:4-30.13 Severability
- 11:4-30.14 Effect on previously filed forms

SUBCHAPTER 31. TERM LIFE INSURANCE COMPARISON SURVEY

- 11:4-31.1 Purpose and scope
- 11:4-31.2 Definitions
- 11:4-31.3 Coverage option survey
- 11:4-31.4 Survey forms

APPENDIX A

APPENDIX B

APPENDIX C

SUBCHAPTER 32. VALUATION OF LIFE INSURANCE POLICIES

- 11:4-32.1 Purpose and scope
- 11:4-32.2 Definitions
- 11:4-32.3 General calculation requirements for basic reserves and premium deficiency reserves
- 11:4-32.4 Calculation of minimum valuation standard for policies with guaranteed non-level gross premiums or guaranteed non-level benefits (other than universal life policies)
- 11:4-32.5 Calculation of minimum valuation standard for flexible premium and fixed premium universal life insurance policies that contain provisions resulting in the ability of a policyowner to keep a policy in force over a secondary guarantee period
- 11:4-32.6 Operative date

APPENDIX. SELECT MORTALITY FACTORS

SUBCHAPTER 33. EXCESS INTEREST RESERVE ADJUSTMENT

- 11:4-33.1 Purpose
- 11:4-33.2 Applicability and scope
- 11:4-33.3 Requirements
- 11:4-33.4 Separability

SUBCHAPTER 34. LONG-TERM CARE INSURANCE

- 11:4-34.1 Purpose
- 11:4-34.2 Applicability and scope
- 11:4-34.3 Definitions

ACTUARIAL SERVICES

- 11:4-34.4 Filing requirement
- 11:4-34.5 Policy definitions
- 11:4-34.6 Policy practices, provisions and prohibitions
- 11:4-34.7 Continuation or conversion of group coverage
- 11:4-34.8 Required disclosure provisions
- 11:4-34.9 Requirements for replacement
- 11:4-34.10 Discretionary powers of the Commissioner
- 11:4-34.11 Outline of coverage
- 11:4-34.12 Severability
- 11:4-34.13 Actuarial requirements for rate submissions
- 11:4-34.14 Loss ratio standards for individual long-term care insurance
- 11:4-34.15 Spousal discount

SUBCHAPTERS 35 THROUGH 36. (RESERVED)

SUBCHAPTER 37. SELECTIVE CONTRACTING ARRANGEMENTS OF INSURERS

- 11:4-37.1 Purpose and scope
- 11:4-37.2 Definitions
- 11:4-37.3 Standards for selective contracting arrangements
- 11:4-37.4 Selective contracting arrangement approval and amendment procedures
- 11:4-37.5 Confidentiality
- 11:4-37.6 Denial, suspension and revocation
- 11:4-37.7 Monitoring; auditing
- 11:4-37.8 Filing and review fees
- 11:4-37.9 Penalties

SUBCHAPTERS 38 THROUGH 39. (RESERVED)

SUBCHAPTER 40. LIFE/HEALTH/ANNUITY FORMS

- 11:4-40.1 Purpose and scope
- 11:4-40.2 Definitions
- 11:4-40.3 Life/health/annuity form approval standards
- 11:4-40.4 General requirements
- 11:4-40.5 Life/health/annuity form approval procedures
- 11:4-40.6 Individual life and annuities variable form approval procedures
- 11:4-40.7 Valuation and non-forfeiture interest rates form approval procedures
- 11:4-40.8 Certificate of assumption form approval procedures
- 11:4-40.9 File and use eligibility
- 11:4-40.10 File and use procedures
- 11:4-40.11 Service fees

APPENDIX

SUBCHAPTER 41. STANDARDS FOR INDIVIDUAL LIFE INSURANCE POLICY FORMS

- 11:4-41.1 Purpose and scope
- 11:4-41.2 Definitions
- 11:4-41.3 General standards
- 11:4-41.4 Exclusions and prohibitions
- 11:4-41.5 Prohibition of bail-out features
- 11:4-41.6 Indexed benefits
- 11:4-41.7 Standards for pre-existing conditions exclusions
- 11:4-41.8 Standards for field issue contracts
- 11:4-41.9 Standards for extension or cancellation of maturity dates
- 11:4-41.10 Standards for policy split options
- 11:4-41.11 Standards for other insured coverage
- 11:4-41.12 Standards for designated life options
- 11:4-41.13 Standards for survivorship forms
- 11:4-41.14 Standards for re-entry or requalification features
- 11:4-41.15 Standards for custom design products
- 11:4-41.16 Effect on previously filed forms

SUBCHAPTER 42. GROUP LIFE, GROUP HEALTH AND BLANKET INSURANCE: GENERAL STANDARDS FOR CONTRACT PROVISIONS

- 11:4-42.1 Purpose and scope
- 11:4-42.2 Definitions

- 11:4-42.3 Applicability of other standards
- 11:4-42.4 General standards
- 11:4-42.5 Prohibited provisions
- 11:4-42.6 Provisions for aggregate limits
- 11:4-42.7 Provisions for offsets in group policies and certificates providing disability income insurance
- 11:4-42.8 Provisions setting forth pre-authorization requirements
- 11:4-42.9 Provisions for pre-existing condition exclusions and limitations
- 11:4-42.10 Provisions for subrogation and repayment of benefits
- 11:4-42.11 Provisions concerning exclusions and limitations for the use of alcohol and drugs or relating to illegal occupations
- 11:4-42.12 Provisions for payment of benefits payable for automobile related injuries
- 11:4-42.13 Conversion of group life insurance coverage to an individual life insurance policy

APPENDIX. BENEFITS PAYABLE FOR AUTOMOBILE RELATED INJURIES

SUBCHAPTER 43. INDIVIDUAL ANNUITY CONTRACT FORM STANDARDS

- 11:4-43.1 Purpose and scope
- 11:4-43.2 Definitions
- 11:4-43.3 General requirements and prohibitions
- 11:4-43.4 Individual immediate annuities
- 11:4-43.5 Individual deferred annuities
- 11:4-43.6 Waiver of surrender charges
- 11:4-43.7 Surrender charges for individual deferred annuities

SUBCHAPTER 44. STANDARDS FOR CONTRACTS ON A VARIABLE BASIS

- 11:4-44.1 Purpose and scope
- 11:4-44.2 Definitions
- 11:4-44.3 Standards for variable contracts
- 11:4-44.4 Prohibited provisions
- 11:4-44.5 Standards for individual market value adjusted annuities

SUBCHAPTER 45. PERIODIC REPORTS

- 11:4-45.1 Purpose and scope
- 11:4-45.2 Definitions
- 11:4-45.3 General requirements
- 11:4-45.4 Flexible factor forms; reporting requirements
- 11:4-45.5 Individual variable annuity forms; reporting requirements
- 11:4-45.6 Variable life insurance; periodic report requirements
- 11:4-45.7 Illustrated forms
- 11:4-45.8 Penalties

SUBCHAPTER 46. SYNTHETIC GUARANTEED INVESTMENT CONTRACT FORMS

- 11:4-46.1 Purpose and Scope
- 11:4-46.2 Definitions
- 11:4-46.3 Form submission requirements
- 11:4-46.4 Plan of operation requirements
- 11:4-46.5 Contract requirements
- 11:4-46.6 General requirements
- 11:4-46.7 Reserves
- 11:4-46.8 Severability

SUBCHAPTER 47. ACTUARIAL REQUIREMENTS FOR FLEXIBLE-FACTOR POLICY FORMS

- 11:4-47.1 Purpose and Scope
- 11:4-47.2 Definitions
- 11:4-47.3 General requirements
- 11:4-47.4 Pricing assumptions—actuarial certification
- 11:4-47.5 Nonforfeiture benefits—actuarial memorandum
- 11:4-47.6 Recordkeeping
- 11:4-47.7 Penalties

APPENDIX. DETECTION AND AVOIDANCE OF
DISCONTINUITIES IN LIFE INSURANCE
POLICIES

SUBCHAPTER 48. UNFAIR DISCRIMINATION

- 11:4-48.1 Purpose and scope
- 11:4-48.2 Definitions
- 11:4-48.3 General requirements
- 11:4-48.4 Persistency bonus
- 11:4-48.5 Tiered factors
- 11:4-48.6 Conversion credits
- 11:4-48.7 Non-smoker only coverage
- 11:4-48.8 Policy benefits determined by ownership
- 11:4-48.9 Forgiveness of surrender charge
- 11:4-48.10 Discounts and reductions in premium in individual health insurance

SUBCHAPTER 49. MANDATED DIABETES BENEFITS

- 11:4-49.1 Purpose and scope
- 11:4-49.2 Definitions
- 11:4-49.3 Benefits
- 11:4-49.4 Payment of benefits under multiple coverage plans

SUBCHAPTER 50. REIMBURSEMENT OF INMATE
HEALTH CARE COSTS

- 11:4-50.1 Purpose and scope
- 11:4-50.2 Definitions
- 11:4-50.3 Liability for medical care
- 11:4-50.4 Amount of inmate liability
- 11:4-50.5 Health coverage plans
- 11:4-50.6 Filing of claims for reimbursement
- 11:4-50.7 Coordination of benefits
- 11:4-50.8 Policy forms

SUBCHAPTER 51. (RESERVED)

SUBCHAPTER 52. LIFE INSURANCE ILLUSTRATIONS

- 11:4-52.1 Purpose and scope
- 11:4-52.2 Definitions
- 11:4-52.3 Policies to be illustrated
- 11:4-52.4 General rules and prohibitions
- 11:4-52.5 Standards for basic illustrations
- 11:4-52.6 Standards for supplemental illustrations
- 11:4-52.7 Delivery of illustration and record retention
- 11:4-52.8 Annual report; notice to policy owners
- 11:4-52.9 Annual certifications
- 11:4-52.10 Penalties
- 11:4-52.11 Transition

SUBCHAPTER 1. (RESERVED)

SUBCHAPTER 2. REPLACEMENT OF LIFE
INSURANCE POLICY

11:4-2.1 Purpose

(a) The purpose of this subchapter is:

1. To regulate the activities of insurers and agents with respect to the replacement of existing life insurance;

2. To protect the interests of life insurance policyowners by establishing minimum standards of conduct to be observed in the replacement or proposed replacement of existing life insurance by:

i. Assuring that the policyowner receives information with which a decision can be made in his or her own best interest;

ii. Reducing the opportunity for misrepresentation and incomplete disclosures; and

iii. Establishing penalties for failure to comply with the requirements of this subchapter.

11:4-2.2 Definitions

“Cash dividend” means the current illustrated dividend which can be applied toward payment of the gross premium.

“Conservation” means any attempt by the existing insurer or its agent to continue existing life insurance in force when existing insurer has received a Comparative Information Form as required by N.J.A.C. 11:4-2.5(a)3iv from a replacing insurer. A conservation effort does not include routine administrative procedures like late payment reminders, late payment offers or reinstatement offers.

“Direct-response sales” means any sale of life insurance where the insurer does not utilize an agent in the sale or delivery of the policy.

“Existing insurer” means the insurance company whose policy is or will be changed or terminated in such a manner as described within the definition of “replacement”.

“Existing life insurance” means any life insurance in force including life insurance under a binding or conditional receipt or a life insurance policy that is within an unconditional refund period, but excluding life insurance obtained through the exercise of a dividend option.

“Generic name” means a short title which is descriptive of the premium and benefit patterns of a policy or a rider.

“Replacement” means any transaction in which new life insurance is to be purchased, and it is known or should be known to the proposing agent, or to the proposing insurer if there is no agent, that by reason of such transaction, existing life insurance has been or is to be:

1. Lapsed, forfeited, surrendered, or otherwise terminated;

2. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

3. Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

4. Reissued with any reduction in cash value; or

5. Pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time for amounts in the aggregate exceeding 25 percent of the loan value set forth in the policy.

“Replacing insurer” means the insurance company that issues a new policy which is a replacement of existing life insurance.

“Sales Proposal” means individualized, written sales aids of all kinds, excluding Comparative Information Forms and Policy Summaries, which are used by an insurer, agent or broker in comparing existing life insurance to proposed life insurance in order to recommend the replacement or conservation of existing life insurance. Sales aids of a generally descriptive nature, which are maintained in the insurer’s advertising compliance file, shall not be considered a Sales Proposal within the meaning of this definition.

11:4-2.3 Exemptions

(a) Unless otherwise specifically included, this subchapter shall not apply to:

1. Annuities;
2. Individual credit life insurance;
3. Group life insurance, group credit life insurance, and life insurance policies issued in connection with a

pension, profit-sharing or other benefit plan qualifying for tax deductibility of premiums, provided, however, that as to any plan described in this subsection, full and complete disclosure of all material facts shall be given to the administrator of any plan to be replaced;

4. Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account;

5. An application to the existing insurer that issued the existing life insurance and a contractual change or conversion privilege is being exercised;

6. Existing life insurance that is a non-convertible term life insurance policy which will expire in five years or less and cannot be renewed; or

7. Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company.

11:4-2.4 Duties of agent

(a) Each agent shall submit to the replacing insurer with or as part of each application for life insurance:

1. A statement signed by the applicant as to whether or not such insurance will replace existing life insurance; and

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.

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 subchap-

ter 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;
2. An actuarial memorandum which discusses the derivation of cash values and all current and maximum charges deducted in determining the separate account values; and
3. A periodic report which satisfies all reporting requirements set forth at N.J.A.C. 11:4-45.

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;

GROUP HEALTH (SERVICE CORP.)

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

| 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.

SUBCHAPTER 41. STANDARDS FOR INDIVIDUAL LIFE INSURANCE POLICY FORMS

Authority

N.J.S.A. 17:1-8.1, 17:1C-6(e), and P.L.1995, c.73.

Source and Effective Date

R.1996 d.197, effective April 15, 1996.
See: 27 N.J.R. 3727(a), 28 N.J.R. 1992(a).

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 Insurance.

"Department" means the New Jersey Department of Insurance.

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).

“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.

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 re-entry 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 policies shall be designated as participating or nonparticipating.

7. 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.

8. 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, except that if the insurer uses a current rate rather than a guaranteed rate to compute the cash surrender value, the rate credited to loan amounts shall be at least the policy loan rate used less no more than two percentage points.

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 include in its submission a signed written agreement, which shall include the following:

(1) The insurer shall agree to 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) The insurer shall agree to 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) The insurer shall agree to notify the policyholder in writing at least 10 days prior to the effective date of any increase in the interest rate.

9. 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)9iii(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)9ii 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.

10. 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. The following requirements apply to scheduled premium policies which allow the payment of additional premiums whether used solely to increase the account value or the face amount:

(1) Any restrictions on the amount and timing of additional premiums shall be fair, reasonable and adequately disclosed in the form. The form shall include any upper and/or lower limits on additional premium payments. The form shall not include any provision which permits the insurer to arbitrarily refuse additional premium payments.

(2) The insurer shall indicate in its submission to the Department how the insurer shall prevent the contract from losing life insurance qualifications or being reclassified as a modified endowment contract as a result of additional premiums.

(3) Any requirement of additional evidence of insurability or imposition of additional contestability and suicide provisions on additional premiums received after issue shall be described in the form, and shall be limited in applicability to any increase in the amount at risk due to the additional premiums. In general, such increase in amount at risk shall only take place as a result of IRS corridor requirements or as a result of purchase of paid-up additions.

(4) Any distinction between the interest rates, expense charges, or mortality charges on amounts purchased by additional premiums and amounts purchased by the premiums required under the policy shall be disclosed in the form, and shall be actuarially demonstrated in an accompanying memorandum to be fair and equitable. (For example, many insurers charge a lower expense loan on additional premiums reflecting different commissions or fixed expenses.) However, different interest rates on additional premium funds shall be closely scrutinized. The form shall set forth the amount of any differences in guaranteed charges or credits, as well as the existence (although not the amount) of any differences in nonguaranteed premiums or charges.

(5) Account value increases as a result of additional premiums shall not be subject to surrender charges or expense loadings in excess of those allowed for single premium annuities pursuant to N.J.S.A. 17B:25-20.

viii. 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)10viii(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)10viii(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.

11. 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.

iii. The insurer shall not require the submission of claim forms.

12. 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.

13. 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.

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 extension or cancellation of maturity dates

(a) A form which includes a provision for maturity of the policy on a specified date may include an option for deferral of maturity until a later date or until the actual date of death only if the following standards are met:

1. The death benefit shall never be less than the cash surrender value;
2. The policy shall not require, but may permit, payment of premiums on and after the original maturity date;
3. If no premiums are paid on and after the original maturity date, the present value (on the guaranteed mortality and interest basis) of the death benefits after the original maturity date plus the maturity value on any specified deferred maturity date shall be at least equal to the maturity value on the original maturity date;
4. The cost of insurance or mortality charge on the guaranteed basis for any class of risk shall not exceed a monthly rate of \$50.00 per \$1,000 net amount at risk on any date beyond the original maturity date of the contract;
5. Any provision for experience adjustment of policy costs or benefits, either retrospectively through dividends or prospectively through flexible pricing factors, shall continue on a consistent basis;
6. The cash surrender value on any anniversary after the original maturity date shall be the present value (on the guaranteed mortality and interest basis) of the future guaranteed benefits, including any additional benefits arising from experience adjustments or additional premiums paid. In the case of a policy with values based on a retrospective fund accumulation, the cash surrender value will equal the fund balance; and
7. All other policy provisions required by statute shall continue to apply after the original maturity date (including, but not limited to, provisions with respect to policy

loans and surrenders). Periodic reports shall continue to be provided after the original maturity date.

11:4-41.10 Standards for policy split options

(a) The following standards shall apply to policy split options:

1. Unless the option states otherwise, the type (for example, universal life) of policy shall be the same as that of the multiple life policy. If the option indicates that there is a difference in the type of policy, the insurer shall provide an explanation in the submission as to the reason for providing different coverage. The insurer shall maintain on file individual policies in order to meet this contractual obligation.

2. The form shall specify any premium or other charge for the option, and the submission shall include the actuarial basis for such premium or charge.

3. The option shall clearly indicate whether or not evidence of insurability is required for the split policy option to be elected.

4. The option shall indicate the amount from the original policy that will be available to the individual policies, how it will be divided, and whether it will be credited to the individual policy as a premium or as an increase in cash value. The option shall clearly indicate the expense charges or surrender charges that will be applicable under the individual policies. The individual policies shall be endorsed if insurer practice concerning the policy split option is inconsistent with the terms of the individual policy.

5. The free look or right to examine provision of the individual policy shall comply with N.J.S.A. 17B:25-2.1, which requires a refund of any premiums paid, including any policy fees or other charges. The insurer shall not deduct any surrender charges or fees from the original multiple life policy in calculating the refund. In administering this provision, the premium refunded shall include all amounts from the original policy applied to the new policies.

6. The issuance of the individual policies shall satisfy any requirements for insurable interest.

11:4-41.11 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.

11:4-41.12 Standards for designated life options

(a) The following requirements shall apply to designated life options:

1. Backdating of the new policy shall be limited to six months.

2. The insurer shall guarantee that insurable interest requirements at the time the new policy is issued are satisfied.

11:4-41.13 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 not be permitted to avoid the provision of single life coverage on the life of the survivor even if such surviving insured is uninsurable at the time of the death, was uninsurable at the time the original policy was issued, or is in a different premium class at the time of

the death than at the time the original policy was issued; 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.

11:4-41.14 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.

11:4-41.15 Standards for custom design products

(a) The Department shall permit the use of a single policy form to provide more than one product where there are distinguishable alternative plans. The plans are distinguishable if the schedule pages and any related tables of values have unique identifying form numbers, and a separate actuarial memorandum exists for each plan.

(b) The use of single policy forms to provide more than one product shall be permitted under the following circumstances:

1. Whole life coverage where the only difference is the length of the premium paying period.

2. Decreasing term plans where the only difference is the length of the term period. The Department shall permit different amortization schedules to be used with each term period.

3. Level term plans where the only difference is the length of the term.

(c) The use of single policy forms to provide more than one product shall not be permitted under the following circumstances:

1. A policy form may not be issued as both a single premium plan and a multiple premium plan.

2. A policy form may not be issued with more than one mortality table. Separate policy forms are required for the 1980 CSO Table, 1980 CSO Smoker/Nonsmoker, and each gender blended version of these tables.

3. A policy form may not be issued with more than one scale of guaranteed interest rate(s) used in determining cash values.

4. A policy form may not be issued both for plans which are exempt from providing cash values under the Standard Nonforfeiture Law (N.J.S.A. 17B:25-19) and for plans which are required to provide cash values.

5. A policy form providing term coverage may not be issued for separate plans providing a level death benefit or a non-level death benefit.

6. A policy form may not be issued as both a single life plan and a multiple life plan.

7. A policy form may not be issued as both a first-to-die and a survivorship plan.

8. A policy form may not be issued both with and without a re-entry or requalification provision.

9. A policy form may not be issued both with and without a minimum premium period, or for minimum premium periods of different durations.

10. A policy form may not be issued both with and without a surrender charge.

11. A policy form may not be issued by an agent in the field and by the home office.

12. A policy form may not be issued both as a renewable and nonrenewable term plan.

11:4-41.16 Effect on previously filed forms

Forms which have been filed by the Commissioner pursuant to N.J.S.A. 17B:25-18 containing provisions not in compliance with these rules shall be deemed withdrawn as of December 31, 1996.

Amended by R.1997 d.60, effective February 3, 1997.

See: 28 N.J.R. 4563(a), 29 N.J.R. 425(c).

Substituted "December 31, 1996" for "six months following the effective date of these rules".

SUBCHAPTER 42. GROUP LIFE, GROUP HEALTH AND BLANKET INSURANCE: GENERAL STANDARDS FOR CONTRACT PROVISIONS

Authority

N.J.S.A. 17:1-8.1, 17:1C-6 and P.L.1995, c.73.

Source and Effective Date

R.1996 d.196, effective April 15, 1996.
See: 27 N.J.R. 3735(a), 28 N.J.R. 2003(a).

11:4-42.1 Purpose and scope

(a) This subchapter sets forth standards for provisions contained in group life, group health and blanket insurance contract, policy and certificate forms to assure that the provisions are not unjust, unfair, inequitable, misleading, confusing or unreasonably restrictive and that the coverage provided is not so limited as to provide no substantial economic value.

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.

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 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 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.

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.

SUBCHAPTER 43. INDIVIDUAL ANNUITY CONTRACT FORM STANDARDS

Authority

N.J.S.A. 17:1-8.1, 17:1C-6(e) and P.L.1995, c.73, section 16(e).

Source and Effective Date

R.1996 d.181, effective April 1, 1996.
See: 27 N.J.R. 3740(a), 28 N.J.R. 1885(a).

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

(b) Individual annuity contract forms shall not contain any provisions which are unjust, unfair, inequitable, ambiguous, misleading, likely to result in misinterpretation or are contrary to law.

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

1. Separate contract forms with distinct identifying form numbers shall be submitted where the plan may be issued with or without a bail-out feature.

2. 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.

3. If a form offers varying interest rate guarantee periods, specimen specification pages shall be submitted for each of the various guarantee periods. Each alternate set of specification pages shall have a unique identifying number and be filed with the Commissioner.

4. 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.

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 insurer shall demonstrate as part of the filing that the benefit is an incidental health benefit permitted in an annuity contract pursuant to N.J.S.A. 17B:17-5;

2. The benefit shall be at least as favorable as any other provisions of the contract allowing for penalty-free withdrawals including, but not limited to, any waiting period or proof of loss requirement; and

3. 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 insurer shall demonstrate as part of the filing that the benefit is an incidental life benefit permitted in an annuity contract pursuant to N.J.S.A. 17B:17-5;

2. The benefit shall be at least as favorable as any other provisions of the contract allowing for penalty-free withdrawals including, but not limited to, any waiting period or proof of loss requirement. If the contract contains no other provision for penalty-free withdrawals which are subject to a waiting period, then the terminal illness benefit shall not contain a waiting period requirement (except in the case of presumed, as opposed to diagnosed, terminal illness);

3. 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;

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

5. 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

6. 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.

11:4-43.7 Surrender charges for individual deferred annuities

(a) Submissions of individual deferred annuity contract provisions, riders and endorsements requiring payment to

commence by a fixed age in order to conform the contract to specific sections of the Internal Revenue Code (for example, I.R.A. endorsements) shall be deemed to mature at such age and shall include a certification from a qualified actuary, which shall include the following:

1. A statement that the insurer acknowledges the possible violation of N.J.S.A. 17B:25-20 resulting from a rider, endorsement or policy provision which requires maturity at a fixed age;

2. A statement that the actuary providing the certification has reviewed the policy provision or each and every contract to which a rider or endorsement will be attached, and has determined that each such contract is not in violation of N.J.S.A. 17B:25-20;

3. A list of all contracts to which the rider or endorsement shall be attached, including the form numbers of such contracts and the dates such contracts were filed by or with the Commissioner; and

4. A statement that the rider or endorsement shall not be used with any other contract(s) without the Department's prior written approval.

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

(c) All individual deferred annuity contracts having separate surrender charges associated with each premium payment shall include a provision that upon a partial withdrawal or surrender, the premium payment producing the lowest surrender charge shall be surrendered first. If more than one premium payment produces the same surrender charge, the oldest of those premium payments shall be surrendered first.

SUBCHAPTER 44. STANDARDS FOR CONTRACTS ON A VARIABLE BASIS

Authority

N.J.S.A. 17:1-8.1, 17:1C-6(e), 17B:28-14, 17B:28-15; and P.L. 1995, c.73, sections 16e and 22.

Source and Effective Date

R.1996 d.149, effective March 18, 1996.
See: 27 N.J.R. 3743(a), 28 N.J.R. 1546(a).

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 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 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.

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 statement that a fee is paid to an investment adviser or manager, if applicable;
2. A provision describing the periodic reports;
3. 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

4. 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 \$500.00. 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.

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.

“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 nonforfeiture 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.

“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. Such a contract which includes extra benefits of the kinds set forth in N.J.S.A. 17B:17-3 or 17B:17-4 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 Insurance.

“Contract on a variable basis” 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 Insurance.

“Flexible-factor form” means any life insurance policy, rider or endorsement, whether participating or non-participating, 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 or annuities in this State pursuant to Title 17B of the New Jersey Statutes.

“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 includes also the granting of endowment benefits and optional modes of settlement of proceeds of life insurance as well as provisions for additional benefits in event of death by accident or accidental means or in event of dismemberment or loss of sight, or safeguarding such insurance against lapse or giving a special surrender value or special benefit or an 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 workmen’s compensation coverages.

SUBCHAPTER 45. PERIODIC REPORTS**Authority**

N.J.S.A. 17:1-8.1, 17:1C-6(e), 17B:25-18, 17B:25-19, 17B:27-25, 17B:28-5, 17B:30-1 et seq.; and P.L. 1995, c.73.

Source and Effective Date

R.1996 d.150, effective March 18, 1996.
See: 27 N.J.R. 3744(a), 28 N.J.R. 1548(a).

11:4-45.1 Purpose and scope

(a) These rules set forth the standards and requirements for periodic reports required to be provided to policyholders or contract holders in connection with flexible-factor life insurance forms, individual variable annuity forms, and variable life insurance forms to be filed by the Commissioner for use and delivery in this State pursuant to N.J.S.A. 17B:25-18, 17B:25-18.1, 17B:25-18.2, 17B:27-25, and 17B:28-5. These rules also set forth periodic report requirements for all forms for which illustrations are used pursuant to N.J.A.C. 11:4-52.

(b) These rules shall apply to any insurer seeking to deliver or issue for delivery in this State a flexible-factor form, individual variable annuity form or variable life insurance form; or any other form for which illustrations are used pursuant to N.J.A.C. 11:4-52 as set forth in N.J.A.C. 11:4-45.7.

Amended by R.1998 d.337, effective July 6, 1998.
See: 30 N.J.R. 275(a), 30 N.J.R. 2492(a).

Substituted references to variable life insurance forms for references to individual variable life insurance forms throughout; in (a), inserted references to N.J.S.A. 17B:25-18.1 and 17B:25-18.2, deleted a reference to P.L. 1995, c.73 and added a second sentence; and in (b), added a reference to other forms for which illustrations are used.

11:4-45.2 Definitions

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

"Variable annuities" or "variable life insurance" means annuity or life insurance, respectively, issued under a contract on a variable basis.

Amended by R.1998 d.337, effective July 6, 1998.

See: 30 N.J.R. 275(a), 30 N.J.R. 2492(a).

Inserted "Account value policy".

11:4-45.3 General requirements

(a) 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.

(b) For any form to which these rules apply, the insurer shall provide the policyholder with a report or notice, as set forth in this subchapter, which provides the information and complies with the standards set forth in this subchapter.

(c) Any form submission to which these rules apply shall be accompanied by a specimen copy of the form of periodic report or form of notice to policyholders, as applicable, that the insurer shall utilize as required pursuant to this subchapter. The form of periodic report or form of notice (that is, amendment, letter or transaction or confirmation notice) may be manually generated.

(d) The specimen report or notice submitted pursuant to (c) above shall reflect the specimen issue of the policy under review. The specimen report or notice shall have valid entries which may be reconciled by the Department in its review, and shall display all transactions, charges, benefits and values allowed under the policies. The terms utilized in the report or notice shall correspond to the terms used in the policy to describe the same values, charges, transactions or benefits.

(e) The insurer shall not alter the types of information provided in the report or notice except upon 60 days' prior written notification to the Department, and provided that such changes are not disapproved by the Department within that 60 day period.

Amended by R.1998 d.337, effective July 6, 1998.

See: 30 N.J.R. 275(a), 30 N.J.R. 2492(a).

In (c), inserted a reference to amendments, letters, and transaction and confirmation notices; in (b), substituted a reference to premium factors for a reference to rating factors in the first sentence; and in (d), inserted a reference to benefits and values in the second sentence and added a reference to benefits in the last sentence.

11:4-45.4 Flexible factor forms; reporting requirements

(a) For any flexible factor form where cash values and/or death benefits are subject to variation on the basis of interest, mortality, or expense factors that may be adjusted by the insurer, or on the basis of premium amounts which the policyholder may unilaterally change or choose not to pay, the insurer shall provide each policyholder with a periodic report to notify each policyholder of his or her values and benefits. The report shall satisfy, at a minimum, the following requirements:

1. The report shall be provided at least annually, and shall show values applicable at both the beginning and end of the period covered by the report;

2. The report shall show the policy status as of a date no more than two months prior to the date of the mailing of the report and shall show all increments and decrements to values and benefits since the date as of which the last previous report provided value and benefit information;

3. Individual premiums received during the period covered by the report shall be identified as to amount, date of receipt, and the date on which the insurer first credited interest thereon, unless this information was previously provided in writing to the policyholder at the time each consideration was received;

4. Interest increments shall not be aggregated over different time periods but rather shall be segregated in sufficient detail to permit verification;

5. The report shall record all interest rates which applied to loaned and unloaned amounts during the reporting period;

i. In the case of policies with "buckets" or "generations" of interest, the Commissioner shall waive the requirement set forth in (a)5 above, upon request of the insurer, if the insurer:

(1) Agrees and states on the report that it will provide information regarding interest rates and the methods utilized to calculate interest credits to loaned and unloaned values to the policyholder upon request and free of charge;

(2) With the form submission, provides a specimen copy of the form of notice to the policyholder to be utilized in accordance with N.J.A.C. 11:4-45.3; and

(3) The insurer demonstrates to the Commissioner that the notice shall record all interest rates which applied to loaned and unloaned amounts during the reporting period, together with the amounts to which such rates apply.

ii. Notwithstanding any waiver granted pursuant to (a)5i above, the report shall indicate the interest rate(s) which applied to new premiums during the reporting period;

6. The report shall display all transactions and charges allowed under the policies, which shall be recorded by date. However, the Commissioner shall waive this requirement with respect to the recording of loan activity, upon request of the insurer, if the insurer:

i. Agrees and states on the report that it will provide this information to the policyholder upon request and free of charge;

ii. With the form submission, provides a specimen copy of the form of notice to the policyholder to be utilized in accordance with N.J.A.C. 11:4-45.3; and

iii. The insurer demonstrates to the Commissioner that the notice shall record all transactions for loan activity by date; and

7. If the value of the policy is such that it would not maintain insurance in-force until the anticipated effective date of the next periodic report, the report shall include a caution that the policy may be in danger of terminating without value in the next 12 months unless additional premium is paid.

(b) For all flexible-factor forms, the insurer shall notify policyholders of changes in the amount of premiums or premium factors. The insurer shall indicate in the cover letter to the submission whether the notification required pursuant to this section shall be by periodic report, amendment to the policy form or letter.

(c) For policies to which (a) above applies, the periodic report set forth in that subsection may be utilized to satisfy the notification requirement set forth in (b) above. If so, the notification to the policyholder shall include any changes in amounts that have occurred since the effective date of the previous report together with any changes that have been finally adopted by the insurer and that will be applicable to the next subsequent reporting period.

(d) For forms which contain non-guaranteed premiums or rating factors, the notification of changes to the premiums or factors shall be in the form of a policy form amendment which shall modify all current and future non-guaranteed premium or rating factors that have changed and that were included in the original policy or in subsequent amendments. Any policy form amendments shall be submitted with the form submission for review and filing by the Commissioner in accordance with applicable law.

Amended by R.1998 d.337, effective July 6, 1998.
See: 30 N.J.R. 275(a), 30 N.J.R. 2492(a).

In (a), added “; together with the amounts to which such rates apply” at the end of 5i(3), and rewrote 6iii; and in (d), inserted “with the form submission” in the last sentence.

11:4-45.5 Individual variable annuity forms; reporting requirements

(a) Any periodic report for use with an individual variable annuity shall satisfy, at a minimum, the following requirements:

1. The report shall be provided at least annually, and shall show the values by fund, sub-account and division (including, but not limited to, dollar and unit values) applicable at both the beginning and end of the period covered by the report;

2. The report shall list the number of units and dollar value of a unit not more than two months prior to the date of the mailing of the report;

3. For the period prior to annuitization, the report shall list the number of units and the unit value by fund, sub-account or division. The units and unit value shall not be listed in the aggregate;

4. Except as provided in (a)5 below, for the period prior to annuitization, the report shall record the following transactions by date:

- i. Premium receipt;
- ii. Loans, incurred and repaid;
- iii. Partial surrenders or withdrawals;
- iv. Transfers; and
- v. Charges;

5. Alternatively to (a)4, for any transactions for which transaction or confirmation notices are sent, the report may show an aggregate amount for each such type of transaction, except that transfers need not be shown;

6. For forms that provide a fixed account or other interest option, all interest credits, rates, and the amounts to which such rates apply for the period covered by the report shall be recorded in a periodic report, or transaction or confirmation notice.

i. In the case of policies with “buckets” or “generations” of interest, the Commissioner shall waive the requirement set forth in (a)6 above, upon request of the insurer, if the insurer:

(1) Agrees and states on the report that it will provide interest rates and crediting methodology to the owner upon request and free of charge;

(2) With the form submission, provides a specimen copy of the form of notice to the owner to be utilized in accordance with N.J.A.C. 11:4-45.3; and

(3) The insurer demonstrates to the Commissioner that the notice shall record all interest rates, together with the amounts to which such rates apply.

ii. Notwithstanding any waiver granted pursuant to (a)6i above, the report shall record the interest rates and credits applied to monies newly allocated to a fixed account option during the reporting period, unless such interest rates and credits are provided by the insurer in a transaction or confirmation notice at the time of allocation; and

7. The report sent after annuitization for variable payments shall provide a reconciliation of annuity payments. The annuity unit values shall be listed by fund, sub-account or division. The units and unit values shall not be listed in the aggregate. For annuitization to fixed payments, no report is required.

Amended by R.1998 d.337, effective July 6, 1998.

See: 30 N.J.R. 275(a), 30 N.J.R. 2492(a).

In (a), inserted 4v, substituted "or" for "and" following "transaction" in 5, rewrote the introductory paragraph and i(3) in 6, and inserted references to credits in 6ii.

11:4-45.6 Variable life insurance; periodic report requirements

(a) Any periodic report for use with a variable life form shall satisfy, at a minimum, the following requirements:

1. The report shall be provided at least annually, and shall show values by fund, sub-account and division (including, but not limited to, dollar and unit values, if the product has unit values) applicable at both the beginning and end of the period covered by the report;

2. The report shall show the policy status as of a date no more than two months prior to the date of the mailing the report and shall show all increments and decrements to values and benefits since the date as of which the last previous report provided value and benefit information;

3. The report shall state that, in accordance with the investment experience of the separate account, the cash values and variable death benefit may increase or decrease;

4. If the report shows projected values, it shall describe the assumptions (premiums, charges, and net return) used to calculate the projections; and

5. If, as of the reporting date, any projected value shown in the report is less than zero, the report shall include a caution that the policy may be in danger of terminating without value in the next 12 months unless additional premium is paid.

(b) Any periodic report for use with a variable life form, which is a flexible factor form where cash values and/or death benefits are subject to variation on the basis of interest, mortality, or expense factors that may be adjusted by the insurer, or on the basis of premium amounts which the policyholder may unilaterally change or choose not to pay, shall satisfy, at a minimum, the following requirements:

1. The report shall include a monthly display of positive and negative investment performance for each sub-account, fund or division of the separate account to which money was allocated during the reporting period;

2. Except as provided in (b)3 below, the report shall record the following transactions by date:

- i. Premium receipt;
- ii. Loans, incurred and repaid;
- iii. Partial surrenders or withdrawals;
- iv. Transfers; and
- v. Monthly deductions;

3. Alternatively to (b)2 above, for any transactions for which transaction or confirmation notices are sent, the report may show an aggregate amount for each such type of transaction, except that transfers need not be shown;

i. The Commissioner shall waive the requirement set forth in (b)2 above for loan activity, upon request of the insurer, if the insurer:

(1) Agrees and states in the report that it will provide this information to the policyholder upon request and free of charges;

(2) With the form submission, provides a specimen copy of the form of notice to the policyholder to be utilized in accordance with N.J.A.C. 11:4-45.3; and

(3) The insurer demonstrates to the Commissioner that the notice shall record transactions set forth in (b)2 above by date for loan activity;

4. The report shall display interest increments separately from other increments and decrements. Interest increments shall not be aggregated over different time periods but shall be segregated in sufficient detail to permit verification; and

5. The report shall record all interest rates which applied to loaned and unloaned amounts during the reporting period;

i. In the case of policies with "buckets" or "generations" of interest, the Commissioner shall waive the requirement set forth in (b)5 above, upon request of the insurer, if the insurer:

(1) Agrees and states in the report that it will provide the interest rates and crediting methodology to the policyholder upon request and free of charge;

(2) With the form submission, provides a specimen copy of the form of notice to the policyholder to be utilized in accordance with N.J.A.C. 11:4-45.3; and

(3) The insurer demonstrates to the Commissioner that the notice shall record all interest rates which applied to loaned and unloaned amounts during the reporting period, together with the amounts to which such rates apply.

ii. Notwithstanding any waiver granted pursuant to (b)5i above, the report shall record the interest rates applied to monies newly allocated to a fixed account option during the reporting period, unless such interest rates are provided by the insurer in a transaction or confirmation notice at the time of allocation.

(c) In addition to the requirements set forth in (a) above, the periodic report and submission shall satisfy the requirement set forth in N.J.A.C. 11:4-45.4(b), (c) and (d).

Amended by R.1998 d.337, effective July 6, 1998.
See: 30 N.J.R. 275(a), 30 N.J.R. 2492(a).

In (a) and (b), substituted references to variable life forms for references to individual variable life forms in the introductory paragraphs; and in (b)5i(3), added “, together with the amounts to which such rates apply” at the end.

11:4-45.7 Illustrated forms

(a) In the case of a policy for which illustrations shall be used pursuant to N.J.A.C. 11:4-52, the insurer shall provide each policyholder or contractholder with a periodic report on the status of the policy, which shall satisfy the following requirements:

1. The report shall be provided at least annually;
2. For fixed premium account value policies, if assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report;
3. For flexible premium account value policies, if assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to this effect shall be included in the report;
4. For all other policies, the report shall show, where applicable:
 - i. Current death benefit;
 - ii. Annual contract premium;
 - iii. Current cash surrender value;
 - iv. Current dividend;
 - v. Application of current dividend; and
 - vi. Amount of outstanding loan.

(b) Insurers writing life insurance policies that do not build nonforfeiture values shall only be required to provide a periodic report pursuant to this section with respect to these policies for those years when a change has been made to non-guaranteed policy elements by the insurer.

(c) If the periodic report does not include an in force illustration, it shall contain the following notice displayed prominently: “IMPORTANT POLICY OWNER NOTICE: You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling (insurer's phone number), writing to (insurer's name) at (insurer's address) or contacting your agent. If you do not receive a current illustration of your policy within 30 days from your request, you should contact your state insurance department.” The

insurer may vary the sequential order of the methods for obtaining an in force illustration.

(d) If an adverse change in non-guaranteed elements that could affect the policy has been made by the insurer since the last periodic report, the report shall contain a notice of that fact and the nature of the change prominently displayed.

(e) For flexible-factor forms, the report shall satisfy all of the applicable requirements of this subchapter in addition to the requirements set forth in this section.

New Rule, R.1998 d.337, effective July 6, 1998.

See: 30 N.J.R. 275(a), 30 N.J.R. 2492(a).

Former N.J.A.C. 11:4-45.7, Penalties, recodified to N.J.A.C. 11:4-45.8.

11:4-45.8 Penalties

Failure to comply with this subchapter shall result in the disapproval of any flexible-factor form, individual variable annuity form, or variable life insurance form, or any form for which an illustration is used pursuant to N.J.A.C. 11:4-52, as applicable, for delivery in this State, as well as the imposition of any other penalties as may be authorized by law.

Recodified from N.J.A.C. 11:4-45.7 and amended by R.1998 d.337, effective July 6, 1998.

See: 30 N.J.R. 275(a), 30 N.J.R. 2492(a).

Substituted a reference to variable life insurance forms for a reference to individual life insurance forms and inserted a reference to forms for which illustrations are used pursuant to N.J.A.C. 11:4-52.

SUBCHAPTER 46. SYNTHETIC GUARANTEED INVESTMENT CONTRACT FORMS

Authority

N.J.S.A. 17:1-8.1, 17:1-15(e), 17B:28-7,
17B:28-14 and P.L. 1995, c.73.

Source and Effective Date

R.1997 d.332, effective August 4, 1997.
See: 29 N.J.R. 1472(a), 29 N.J.R. 3452(b).

11:4-46.1 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 the terms and conditions under which life insurance companies may issue synthetic guaranteed investment contracts, the essential operational features of the segregated portfolio of assets required to issue such contracts and the reserve requirements for such contracts.

(b) This subchapter shall apply to all synthetic guaranteed investment contract forms delivered or issued for delivery in the State.

11:4-46.2 Definitions

The following words and terms, as 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.

Source and Effective Date

R.1996 d.182, effective April 1, 1996.
See: 27 N.J.R. 3756(a), 28 N.J.R. 1887(a).

11:4-48.1 Purpose and scope

(a) This subchapter sets forth standards and requirements that all life and health insurance policy forms and annuity contract forms are required to meet in order to comply with the prohibition against unfair discrimination as provided at N.J.S.A. 17B:30-12.

(b) These rules shall apply to all insurers delivering or issuing for delivery life insurance and health insurance policies or annuity contracts in this State.

11:4-48.2 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 coming 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.

“Commissioner” means the Commissioner of the New Jersey Department of Insurance.

“Department” means the New Jersey Department of Insurance.

“Health insurance” is as defined at N.J.A.C. 11:4-40.2.

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

“Life insurance” is as defined at N.J.A.C. 11:4-40.2.

“Persistency bonus” means any credit to an explicit or implicit accumulation account which varies by duration in a manner which encourages or rewards persistency, and which includes:

1. A retroactive refund of past mortality or expense charges at some duration;
2. A retroactive increase in past interest credits at some duration;
3. A percentage increase in the accumulation amount at some duration; and
4. Factor enhancement bonuses which provide for the crediting of a higher interest rate or the charging of a

lower expense or mortality charge commencing at some duration.

“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 or tiers of a policy amount. Tiered factors reflect economies of scale or other economies so that credits will increase with size and charges will decrease with size. Tiered factors do not include factors which vary by policy duration.

11:4-48.3 General requirements

(a) No insurer shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged, dividends or other benefits payable thereon, or in any other of the terms and conditions for any policy of life insurance or contract of annuity.

(b) No insurer shall make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium policy fees, or rates charged for any policy or contract of health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such policy or contract, or in any other manner whatsoever.

11:4-48.4 Persistency bonus

(a) The Department shall approve life insurance policy forms that provide non-guaranteed bonuses which either credit a higher interest rate or charge a lower expense or mortality charge commencing at some duration if all of the following conditions are met:

1. The intention to pay bonus interest or reduce mortality or expense charges shall be stated in the contract or in an endorsement thereto which has been filed by the Department prior to use. Such contract wording or endorsement shall not constitute a guarantee of the payment of the bonus. An example of acceptable language is as follows: The company may credit interest at a rate in excess of the guaranteed rate. Additional interest at a rate of not more than may be credited to policies in force at least 10 years, as well as for policies in force more than 20 years. The additional excess interest is the result of a reduction in the interest margin for profit and expenses. The guaranteed interest rate will not be increased by the additional excess interest rate.

2. The insurer shall include in its submission to the Department an actuarial memorandum which demonstrates that the nonguaranteed bonus does not unfairly discriminate between persons who lapse or surrender their policies before the policy year of crediting the bonus and those who continue their policy in force, as prohibited

by N.J.S.A. 17B:30-12(c). The actuarial memorandum shall include:

i. An explanation of the reason for and source of the bonus which focuses on the completion of amortization expenses and the release of interest margins. Higher investment yields on long term assets or hypothetically better mortality of persisting policyholders will not provide sufficient justification for a bonus;

ii. A calculation of the asset share for two typical pricing cells, including the components of the asset share (premiums, benefits, etc.) and a comparison of the asset share of the cash value of all durations;

iii. For a typical pricing cell, the amount of acquisition cost, and a quantitative description of how that amount is recovered through interest margins and cost of insurance margins; and

iv. A demonstration that the policy is not lapse supported by establishing profitability at the pricing cells used in (a)2ii above under the following sets of assumptions:

(1) No bonus, normal lapses;

(2) No bonus, no lapse until bonus period, then normal lapses;

(3) Bonus paid, normal lapses; and

(4) Bonus paid, no lapse until bonus period, then normal lapses. Some elements of this demonstration may be unnecessary in the case of an expense bonus if the reduction is matched to a reduction in expenses such as commission rates.

3. The insurer shall notify the Department in writing at least 60 days prior to implementing any changes in bonus interest rate levels or methodology and any reduction or elimination of bonus provisions. No such changes or reductions shall be implemented without the Department's prior approval. The Department may require the elimination or reduction of the bonus as a condition of approval of some future change in interest rates.

(b) All persistency bonuses other than those described in (a) above shall be prohibited in life insurance policy forms.

11:4-48.5 Tiered factors

(a) The Department shall approve life insurance policy forms that use or may use tiered factors if all of the following requirements are met:

1. The tiered factor shall be described in the contract. The contract shall identify the specific policy amount upon which the factor will vary.

2. The factor differentials shall not result in unfair discrimination between individuals of the same class as prohibited by N.J.S.A. 17B:30-12(c). The insurer shall include with the form submission a demonstration that the tiering is reasonably related to differentials in expenses, mortality, investment return, or some other policy cost factor.

3. The table of factors required by N.J.A.C. 11:4-47 shall include tiered factors.

4. The insurer shall include with the submission of a form containing tiered factors a description of the circumstances under which the tiered factors will be adjusted. Such description is a statement of intent rather than a guarantee of future action. Insurers may state in the form that adjustments will be made based upon a significant change in a particular profit target where such change is measured by some qualitative test. Tiered factors may be adjusted based upon future expectations and shall not distribute prior profits or recoup past losses.

5. The insurer shall notify the Department in writing at least 60 days prior to implementing any changes in the structure of tiered factors, such as the levels at which the factors change or the relative size of the factors for different tiers. Following such notification, the insurer may utilize the new structure without approval of or notification by the Department. This requirement is in addition to any approval and notice requirements which are applicable to changes in factors in the absence of tiering.

6. As a condition to approval of a form with tiered factors, the insurer shall agree that pricing assumptions for inforce policies will be reviewed whenever the factors for comparable new issues are changed, but in no event more often than once each policy year nor less often than once every five policy years. This review is not required during any period that factors are subject to an initial guarantee period. The actuarial memorandum accompanying the submission of a form with tiered factors shall certify that the assumptions are reasonable and self-supporting and do not unfairly discriminate between new issues and inforce policies.

11:4-48.6 Conversion credits

(a) The Department shall approve life insurance policy forms that provide conversion credits pursuant to N.J.S.A. 17B:30-14e if all of the following conditions are met:

1. An actuarial certification and numerical demonstration shall be submitted with the form, which demonstrate that the credits for all durations and amounts are reasonably related to the savings in administration and issuance expenses reasonably attributable to the contracts. A statement that the credits are available to all owners under the contracts is not a sufficient demonstration; and

2. Savings in administration and issuance expenses means any net savings arising from the process of conversion, and not normal new business processing. Savings which do not justify conversion credits include differences in anticipated experience with respect to costs controlled by the policyholder such as persistency, loan utilization and selection of policy options.

11:4-48.7 Non-smoker only coverage

The Department shall not approve life insurance policy forms intended for sale to non-smokers. Insurers may decline or not offer insurance to smokers if underwriting considerations based on mortality risk exposure would result in such smokers being ineligible. Insurers shall not decline or refuse to offer insurance to smokers if non-smokers having elevated mortality at least equal to that of smokers are accepted.

11:4-48.8 Policy benefits determined by ownership

The Department shall not approve provisions in life insurance policy forms under which the level of premiums or benefits varies depending solely upon who retains the ownership rights of the policy.

11:4-48.9 Forgiveness of surrender charge

A policy shall not provide credits for a surrender charge imposed under another contract for the reason that such credits unfairly discriminate among contractholders based on the source of funding.

11:4-48.10 Discounts and reductions in premium in individual health insurance

(a) In addition to the discounts based solely on savings in expenses due to the method of premium collection as permitted by N.J.S.A. 17B:30-14d and the discounts based solely on the amount of insurance issued to a particular insured as permitted by N.J.S.A. 17B:30-14e, reductions in premiums for individual health insurance policies based on class as described below are permitted if either of the following conditions are met:

1. A reduced premium may be charged under one individual health policy form based on savings in expenses, improved morbidity or increased persistency resulting from differing marketing or underwriting methods utilized for a particular class of individuals who present the same underlying hazard. Such classes may include associations, employers and large cases. Savings in expenses may include a reduction in commissions or other compensation as applied to all policies within the particular class. Each reduction in premium shall be considered a separate class (for example, 10 percent, 15 percent and 20 percent employer-based reductions in premium shall each be considered a separate class); or

2. The reduction in premium is based on additional requirements applied to the discounts allowed by N.J.S.A. 17B:30-14d and 17B:30-14e. For example, list bill dis-

counts with minimum premium requirements, or list bill discounts which vary based on level of participation are considered a separate class subject to the requirements of this section. Each reduction in premium shall be considered a separate class.

(b) The submission of individual health insurance policy forms which provide reductions in premiums to members of particular classes shall include the following:

1. An actuarial memorandum which shall contain a separate section for each class for which reduced rates are available under the form. The actuarial memorandum shall include the following:

i. A complete description of the class of applicants eligible for the reduced premium;

ii. The objective basis for the premium differential which shall include the different expense, morbidity and persistency assumptions that are used to calculate the reduced premium for the class;

iii. The anticipated loss ratio for the class which shall not be less than the minimum anticipated loss ratio required by N.J.A.C. 11:4-18.5. Any variation from the anticipated loss ratio for the form for regular issues shall be based upon differences in expense and persistency assumptions, and shall be consistent with the objective basis for the differential; and

iv. A certification that the loss experience for each class for which reduced premiums are available under the policy form will be maintained separately from the other experience under the policy form for purposes of determining future rate adjustments;

2. A separate rate sheet which sets forth the following information for each class for which reduced rates are available under the form:

i. The amount of reduction in rates when issued to a member of the class as compared to the rate for regular issues;

ii. All riders currently submitted to, pending with, or approved by the Department, which will be used with the form, together with any reduction in premium for the rider when issued to a member of the class as compared to the rate for the rider when issued to an individual who is not a member of the class; and

iii. Any discounts allowed by N.J.S.A. 17B:30-14d and 17B:30-14e which will be used with the form, and the basis for the discount; and

3. Questions in the application form pertaining to membership in every class for which a reduced premium is offered. The use of different applications for different classes shall be permitted so long as all applications include questions pertaining to membership in every class for which a reduced premium is available.

(c) If an individual is placed in a class at issue which is eligible for a reduced premium not available to members of the general public, such premium classification shall not be changed after issue. The schedule page and form shall include only the premium for that class and shall not contain any reference to the premium for regular issues. The provisions of this paragraph shall not preclude the termination of any discount allowed by N.J.S.A. 17B:30-14d or 17B:30-14e when the individual no longer meets the requirements for such discount.

(d) If an individual is not placed in a class for which he or she is eligible based on the information disclosed in the application, the insurer shall refund to the individual the amount of any overpayment of premium arising from such misclassification.

(e) Insurers submitting different policy forms with essentially identical benefits but with different premiums based on membership in a class, shall be subject to the provisions of (b) through (d) above. At the time of submission, the insurer shall state whether the form submitted is a reduced premium version of another form which has been filed by, is pending with, or is expected to be submitted to the Department.

SUBCHAPTER 49. MANDATED DIABETES BENEFITS

Authority

N.J.S.A. 17:1-15(e), 17B:27-34 et seq., and P.L. 1995, c.331.

Source and Effective Date

R.1997 d.86, effective February 18, 1997.
See: 28 N.J.R. 4340(a), 29 N.J.R. 562(a).

11:4-49.1 Purpose and scope

(a) The purpose of this subchapter is to implement P.L. 1995, c.331 by specifically setting forth the benefits required to be provided pursuant to P.L. 1995, c.331, and by identifying the particular health insurance policy or contract responsible for payment of such benefits.

(b) This subchapter shall apply to all policies and contracts providing hospital or medical expense benefits that are delivered, issued, executed or renewed in this State as follows: 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.; all health insurance policies issued pursuant to N.J.S.A. 17B:26-1 et seq., and 17B:27-26 et seq.; and all health maintenance organization (HMO) contracts issued pursuant to N.J.S.A. 26:2J-1 et seq.

(c) This subchapter shall not apply to any health benefits plans issued pursuant to N.J.S.A. 17B:27A-2 et seq., or 17B:27A-17 et seq., or to any dental only or vision only policy or contract.

11:4-49.2 Definitions

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

“Commissioner” means the Commissioner of the Department of Banking and Insurance.

“Dental only policy or contract” means a policy or contract providing only benefits for dental services.

“Health benefits plan” means any hospital or medical expense insurance policy or contract; health, hospital, or medical service corporation contract; or health maintenance organization subscriber contract delivered or issued for delivery in this State by any carrier. For purposes of this subchapter, “health benefits plan” excludes the following plans, policies, or contracts: accident only, credit health, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers’ compensation or similar law, hospital confinement, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A-1 et seq.) and stop loss or excess risk insurance.

“Vision only policy or contract” means a policy or contract providing only benefits for vision services.

11:4-49.3 Benefits

(a) The diabetes benefits set forth in this subsection shall be included in all health benefits plans.

1. All equipment and supplies for the treatment of diabetes if recommended or prescribed by a physician or nurse practitioner/clinical nurse specialist as follows:

- i. Blood glucose monitors and blood glucose monitors for the legally blind;
- ii. Test strips for glucose monitors and visual reading and urine testing strips;
- iii. Insulin;
- iv. Injection aids;
- v. Cartridges for the legally blind;
- vi. Syringes;
- vii. Insulin pumps and appurtenances thereto;
- viii. Insulin infusion devices; and
- ix. Oral agents for controlling blood sugar; and