

CHAPTER 4
ACTUARIAL SERVICES

Authority

N.J.S.A. 17:1-8.1, 17:1-15e, 17:23-20 et seq.,
17B:18-1 et seq. and 17B:23-1 et seq.

Source and Effective Date

R.2006 d.132, effective March 14, 2006.
See: 37 N.J.R. 4859(a), 38 N.J.R. 1743(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 4, Actuarial Services, expires on September 10, 2013. See: 43 N.J.R. 1203(a).

Chapter Historical Note

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

Subchapter 2, Replacement of Life Insurance Policy, was adopted as R.1972 d.21, effective April 1, 1972.

Subchapter 7, Procedure for the Regulation of Consent to Higher Rate Filings, was adopted as R.1973 d.82, effective April 15, 1973. See: 4 N.J.R. 220(a), 5 N.J.R. 113(b).

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

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

Subchapter 13, Group Student Health Insurance, was adopted as 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 R.1977 d.476, effective December 15, 1977. See: 9 N.J.R. 479(f), 10 N.J.R. 16(d).

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

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

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).

Pursuant to Executive Order No. 66(1978), Subchapter 16, Minimum Standards for Individual Health Insurance, Subchapter 17, Health Insurance Solicitation, and Subchapter 18, Individual Health Insurance Rate Filings, were readopted as R.1980 d.343, effective August 5, 1980. See: 12 N.J.R. 420(c), 12 N.J.R. 538(b).

Subchapter 21, Limited Death Benefits Forms, was adopted as R.1980 d.265, effective June 18, 1980. See: 12 N.J.R. 279(b), 12 N.J.R. 423(c).

Subchapter 2, Replacement of Life Insurance Policy, was repealed and Subchapter 2, Replacement of Life Insurance Policy, was adopted as new rules by R.1982 d.16, effective February 1, 1982, operative June 1, 1982.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).

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

Subchapter 22, Individual Life Insurance: Use of Gender Blended Mortality Tables, was adopted as 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).

Subchapter 23, Medicare Supplement Policies and Contracts, was adopted as 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, Blindness; Partial Blindness or Other Physical or Mental Impairments; Unfair Discrimination, 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), Subchapter 16, Minimum Standards for Individual Health Insurance, Subchapter 17, Health Insurance Solicitation, and Subchapter 18, Individual Health Insurance Rate Filings 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 Nonsmoker Mortality Tables, was adopted as 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 R.1985 d.616, effective December 2, 1985. See: 17 N.J.R. 2349(a), 17 N.J.R. 290(a).

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

Subchapter 19, Optional Coverage for Pregnancy and Childbirth Benefits, was adopted as 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).

Subchapter 29, Homeowners Comparison Survey, was adopted as 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 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 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 R.1989 d.571, effective November 6, 1989. See: 21 N.J.R. 1964(a), 21 N.J.R. 3465(a).

Subchapter 25, Medicare Supplement Interim Standards, was adopted as R.1990 d.214, effective April 16, 1990. See: 22 N.J.R. 320(a), 22 N.J.R. 1266(b).

Pursuant to Executive Order No. 66(1978), Chapter 4 was readopted as R.1991 d.3, effective November 30, 1990, Subchapter 1, Contracts on a Variable Basis, was repealed by R.1991 d.3, 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 R.1991 d.122, effective March 4, 1991. See: 22 N.J.R. 1226(b), 23 N.J.R. 698(a).

Petition for Rulemaking. See: 23 N.J.R. 2546(c), 23 N.J.R. 3827(a).

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

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

Subchapter 9, Personal Lines Insurance: Prospective Loss Costs Filing Procedures, was adopted as 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 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 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).

Administrative correction. See: 27 N.J.R. 4728(a).

Pursuant to Executive Order No. 66(1978), Chapter 4, Actuarial Services, was readopted as R.1996 d.4, effective November 30, 1995, and 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 by R.1996 d.4, effective January 2, 1996. See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

Subchapter 47, Actuarial Requirements for Flexible-Factor Policy Forms, was adopted as new rules by R.1996 d.83, effective February 5, 1996. See: 27 N.J.R. 3750(a), 28 N.J.R. 1215(a).

Subchapter 44, Standards for Contracts on a Variable Basis, was adopted as new rules by R.1996 d.149, effective March 18, 1996. See: 27 N.J.R. 3743(a), 28 N.J.R. 1546(a).

Subchapter 45, Periodic Reports, was adopted as new rules by R.1996 d.150, effective March 18, 1996. See: 27 N.J.R. 3744(a), 28 N.J.R. 1548(a).

Subchapter 43, Individual Annuity Contract Form Standards, was adopted as new rules by R.1996 d.181, effective April 1, 1996. See: 27 N.J.R. 3740(a), 28 N.J.R. 1885(a).

Subchapter 48, Unfair Discrimination, was adopted as new rules by R.1996 d.182, effective April 1, 1996. See: 27 N.J.R. 3756(a), 28 N.J.R. 1887(a).

Subchapter 23A, Medicare Supplement—Under 50 Coverage, and Subchapter 23B, Medicare Supplement—Age 50 through 64 Coverage were adopted as new rules by R.1996 d.195, effective April 15, 1996. See: 27 N.J.R. 3719(a), 28 N.J.R. 1987(a).

Subchapter 42, Group Life, Group Health and Blanket Insurance: General Standards for Contract Provisions, was adopted as new rules by R.1996 d.196, effective April 15, 1996. See: 27 N.J.R. 3735(a), 28 N.J.R. 2003(a).

Subchapter 41, Standards for Individual Life Insurance Policy Forms, was adopted as new rules by R.1996 d.197, effective April 15, 1996. See: 27 N.J.R. 3727(a), 28 N.J.R. 1992(a).

Subchapter 25, Funeral Insurance Policies, was adopted as new rules by R.1996 d.328, effective July 15, 1996. See: 288 N.J.R. 1656(a), 28 N.J.R. 3671(a).

Subchapter 49, Mandated Diabetes Benefits, was adopted as new rules by R.1997 d.86, effective February 18, 1997. See: 28 N.J.R. 4340(a), 29 N.J.R. 562(a).

Subchapter 46, Synthetic Guaranteed Investment Contract Forms, was adopted as new rules by R.1997 d.332, effective August 4, 1997. See: 29 N.J.R. 1472(a), 29 N.J.R. 3452(b).

Subchapter 50, Reimbursement of Inmate Health Care Costs, was adopted as new rules by R.1997 d.513, effective December 1, 1997. See: 29 N.J.R. 2232(a), 29 N.J.R. 5066(a).

Subchapter 52, Life Insurance Illustrations, was adopted as new rules by R.1998 d.338, effective July 6, 1998. See: 30 N.J.R. 47(a), 30 N.J.R. 2495(a).

Subchapter 32, Valuation of Life Insurance Policies, was adopted as new rules by R.1999 d.442, effective December 20, 1999 (operative January 1, 2000, except as provided in N.J.A.C. 11:4-32.6). See: 31 N.J.R. 2845(a), 31 N.J.R. 4268(c).

Pursuant to Executive Order No. 66(1978), Chapter 4, Actuarial Services, was readopted as R.2001 d.7, effective November 30, 2000. See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

Subchapter 1, New Jersey Insolvent Health Maintenance Organization Assistance Association, was adopted as new rules by R.2001 d.122, effective April 2, 2001. See: 32 N.J.R. 3907(a), 33 N.J.R. 1109(a).

Subchapter 35, Viatical Settlements, was adopted as new rules by R.2001 d.226, effective July 2, 2001. See: 33 N.J.R. 162(a), 33 N.J.R. 2300(a).

Subchapter 53, Minimum Standards for Specified Disease and Critical Illness Coverages, was adopted as new rules by R.2001 d.363, effective October 1, 2001. See: 33 N.J.R. 361(a), 33 N.J.R. 3454(c).

Subchapter 6, Reserve Standards for Individual Health Insurance Policies, was repealed and Subchapter 6, Minimum Reserve Standards for Individual and Group Health Insurance Contracts, was adopted as new rules by R.2003 d.38, effective January 21, 2003. See: 34 N.J.R. 3186(a), 35 N.J.R. 437(a).

Subchapter 40A, "40 States" File and Use Standards Procedures, was adopted as new rules by R.2003 d.140, effective April 7, 2003. See: 34 N.J.R. 3916(a), 35 N.J.R. 1555(a).

Subchapter 54, Benefit Standards for Infertility Coverage, was adopted as new rules by R.2003 d.160, effective April 21, 2003. See: 34 N.J.R. 2521(a), 35 N.J.R. 1692(b).

Subchapter 56, Self-Funded Multiple Employer Welfare Arrangements and Insured Multiple Employer Arrangements, was adopted as R.2004 d.212, effective June 7, 2004. See: 35 N.J.R. 3530(a), 36 N.J.R. 2907(a).

Subchapter 27, The 2001 Commissioner's Standard Ordinary (CSO) Mortality Table for Use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits, was adopted as new rules by R.2004 d.415, effective November 1, 2004. See: 36 N.J.R. 3477(a), 36 N.J.R. 4937(a).

Subchapter 55, Pharmacy Cards, was adopted as R.2004 d.433, effective November 15, 2004. See: 36 N.J.R. 1873(a), 36 N.J.R. 5131(a).

Subchapter 57, Mandated Benefits for Biologically-Based Mental Illness, was adopted as new rules by R.2005 d.141, effective May 2, 2005. See: 36 N.J.R. 5080(a), 37 N.J.R. 1523(a).

Subchapter 34, Long-Term Care Insurance, was repealed and Subchapter 34, Long-Term Care Insurance, was adopted as new rules by R.2005 d.422, effective December 19, 2005. See: 36 N.J.R. 5195(a), 37 N.J.R. 5014(b).

Chapter 4, Actuarial Services, was readopted as R.2006 d.132, effective March 14, 2006. See: Source and Effective Date. See, also, section annotations.

Subchapter 2, "Replacement of Life Insurance Policy", was renamed "Life Insurance and Annuities Replacement" by administrative correction, effective June 7, 2006. See: 38 N.J.R. 2834(a).

Subchapter 58, Discretionary Clauses, was adopted as new rules by R.2007 d.152, effective May 7, 2007. See: 38 N.J.R. 3227(a), 39 N.J.R. 1734(a).

Subchapter 27A, Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities, was adopted as new rules by R.2008 d.68, effective March 17, 2008. See: 39 N.J.R. 4540(a), 40 N.J.R. 1666(a).

Subchapter 11, Life Insurance Solicitation, was repealed and Subchapter 11, Life Insurance Disclosure, was adopted as new rules by R.2008 d.71, effective April 7, 2008 (operative July 6, 2008). See: 39 N.J.R. 4065(a), 40 N.J.R. 1882(a).

Subchapter 31, Term Life Insurance Comparison Survey, was repealed by R.2011 d.007, effective January 3, 2011. See: 42 N.J.R. 1845(a), 43 N.J.R. 54(b).

Subchapter 60, Limitations on the Use of Specific Terms or Designations in the Sale of Life Insurance, was adopted as new rules by R.2011 d.088, effective March 7, 2011. See: 42 N.J.R. 2306(a), 43 N.J.R. 637(a).

Subchapter 59, Disclosure and Suitability Requirements for Annuities Directly Solicited to Consumers, was adopted as new rules by R.2011 d.153, effective June 6, 2011. See: 42 N.J.R. 1303(a), 43 N.J.R. 1344(b).

Subchapter 29, Homeowners Comparison Survey, was repealed by R.2011 d.165, effective June 6, 2011. See: 42 N.J.R. 2700(a), 43 N.J.R. 1352(a).

Subchapter 61, Retained Asset Accounts, was adopted as new rules by R.2011 d.228, effective September 6, 2011. See: 43 N.J.R. 723(a), 43 N.J.R. 2346(a).

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4. Paid and incurred/earned loss ratios for each of the years recognized in (c)3 above, where the incurred/earned loss ratio should be calculated both without and with the change in active life reserves;

5. The assumptions used in the calculation of the loss ratio, including:

- i. The annual claim costs (ultimate) by attained age and sex;
- ii. The select and/or anti-select morbidity factors by policy duration (year) by issue age and sex;
- iii. The lapse and mortality rates, by policy duration by issue age and sex;
- iv. The secular trend factors by policy duration by issue age and sex;
- v. The interest rates by policy duration, which rates shall equal a carrier's recent, current and future expected new investment return rates (after investment expenses, but before Federal income taxes). Alternatively, the Department will permit use of a six percent interest rate graded linearly to four percent over 10 years and four percent thereafter or a five percent level interest rate. The Commissioner shall review annually the alternate interest rate and adjust those rates based on corporate bond yields for Aaa and Baa bonds as reported in U.S. Financial Data which is published by the Research and Public Information Division of the Federal Reserve Bank of St. Louis. The Commissioner shall provide public notice of new alternate interest rates by publication in the New Jersey Register;
- vi. Expenses by policy duration, including commission, override and bonus rates; other marketing expense rates; other maintenance expense rates; any new-market expense rates; other acquisition expense rates; and the explicit profit margin or risk charged on a per policy issue, per policy in force, per dollar of claim, per dollar of premium, and any other applicable basis;
- vii. The distribution of expected policies by policy and rider benefits by issue age and sex; and
- viii. A summary statement of the underwriting standards (such as short form medical and risk questionnaire, long form medical and risk questionnaire, medical examination), the marketing distribution system, and the market (that is, the segment(s) of the general public, for example, middle income based on predetermined ZIP code selections) for the policy forms;

6. The specific formulas and methodology used in calculating gross premiums; and

7. A certification signed by an actuary who is a member of the American Academy of Actuaries stating that the assumptions are appropriate to the policy form, reasonably represent the expected experience for the policy form and fully disclose the basis of the calculation of the anticipated loss ratio.

Public Notice: Alternate Interest Rates for Rate Submissions.

See: 39 N.J.R. 3566(b).

Public Notice: Alternate Interest Rates for Rate Submissions.

See: 41 N.J.R. 3855(a).

Public Notice: Alternate Interest Rates for Rate Submissions.

See: 42 N.J.R. 2500(a).

11:4-34.18 Premium rate schedule increases

(a) This section applies to any individual long-term care policy issued in this State on or after January 18, 2006 and for which initial rates were filed pursuant to N.J.A.C. 11:4-34.8.

(b) A carrier shall request approval of a revised premium rate schedule, including an exceptional increase, from the Commissioner at least 60 days prior to sending the notice to be provided to the policyholders, and the carrier's request shall include:

1. Information required by N.J.A.C. 11:4-34.7 concerning disclosure of rating practices;
2. Certification by a qualified actuary that:
 - i. If the requested premium rate schedule increase is implemented and the underlying assumptions for the revised rate filing which reflect moderately adverse conditions are realized, no further premium rate schedule increases are anticipated; and
 - ii. The premium rate filing is in compliance with the provisions of N.J.A.C. 11:4-34.18;
3. An actuarial memorandum justifying the rate schedule change request that includes:
 - i. Lifetime projections of earned premiums and incurred claims (on a year-to-year basis), based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;
 - ii. Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger a contingent benefit upon lapse;
 - iii. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, a comparison of the pricing assumptions and current assumptions and what other actions taken by the carrier have been relied on by the actuary; and
 - iv. A statement that policy design, underwriting and claims adjudication practices have been taken into consideration;
4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the Commissioner; and

5. Sufficient information for review and approval of the premium rate schedule increase by the Commissioner.

(c) All premium rate schedule increases shall be determined in accordance with the following requirements:

1. Exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits whose cost exceeds the assumed cost in the initial premium;

2. Premium rate schedule increases that are not exceptional shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

- i. The accumulated value of the initial earned premium times 58 percent;
- ii. Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;
- iii. The present value of future projected initial earned premiums times 58 percent; and
- iv. Eighty-five percent of the present value of future projected premiums not in (c)2iii above on an earned basis;

3. In the event that a policy form has both exceptional and other increases, the values in (c)2ii and iv above will also include seventy percent for exceptional rate increase amounts; and

4. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in N.J.A.C. 11:4-6.16.

(d) For each rate increase that is implemented, the carrier shall file for approval by the Commissioner updated projections, as defined in (b)3i above, annually for the next three years and include a comparison of actual results to projected values. The Commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that insure 250 or more persons where the policyholder has 5,000 or more eligible employees of a single employer or where the policyholder pays 20 percent or more of the total premium for the group in the calendar year prior to the year a rate increase is filed, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Commissioner.

(e) If any premium rate in the revised premium rate schedule is greater than 150 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in (b)3i above, shall be filed for approval by the Commissioner every five years following the end of the required period in (d) above.

(f) If the Commissioner has determined that the actual experience following a rate increase does not adequately match the projected experiences and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in (c) above, the Commissioner may require the carrier to implement either of the following:

1. Premium rate schedule adjustments; or
2. Other measures to reduce the difference between the projected and actual experience.

(g) If 25 percent or more of the policies to which the increase is applicable are eligible for the contingent benefit upon lapse, the carrier shall file:

1. A plan, subject to Commissioner approval, for improved administration and/or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Commissioner may impose the condition in (h) below; and

2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to (c) above had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in (c)2i and iii above.

(h) If 25 percent or more of the policies to which a rate increase is applicable are eligible for contingent benefit upon lapse, the Commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated.

(i) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evident in the actual results as presented in the updated projections provided by the carrier following the requested rate increase, the Commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the Commissioner may require the carrier to offer, without underwriting, to all in force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the carrier or its affiliates. If the carrier or its affiliates are no longer offering one or more reasonably comparable products, the Commissioner may take other steps, including requiring pooling of all of the carrier's long term care policies for rating purposes, or disapproving or reducing rate increase requests.

1. The offer shall:

- i. Be subject to the approval of the Commissioner;
- ii. Be based on actuarially sound principles, but not on attained age; and
- iii. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by

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

SUBCHAPTERS 38 THROUGH 39. (RESERVED)

SUBCHAPTER 40. LIFE/HEALTH/ANNUITY FORMS

11:4-40.1 Purpose and scope

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

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

11:4-40.2 Definitions

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

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

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

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

“Department” means the New Jersey Department of Banking and Insurance.

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

“Funeral insurance policy” means a policy as defined at N.J.S.A. 17B:17-5.1.

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

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

“Life insurance” means a policy or contract whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the cessation of human life. Life insurance also includes the granting of endowment benefits and optional modes of settlement of proceeds of life insurance, as well as provisions for additional benefits in the event of death by accident or accidental means or in the event of dismemberment or loss of sight; or safeguarding such insurance against lapse or giving a special surrender value, or special benefit or annuity in the event that the insured shall become totally and permanently disabled, whether such provisions are incorporated in a policy or contract of life insurance or in a policy or

contract supplemental thereto. Life insurance does not include worker's compensation coverage.

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

"Private placement form" means an individual variable life insurance form or individual variable annuity form where the purchaser meets the definition of "accredited investor" set forth in Rule 501 of Regulation D under the Securities Act of 1933, 15 U.S.C. §77b.(15) or "qualified purchaser" set forth in Section 2(a)(51) of the Investment Company Act of 1940, 15 U.S.C. §80a-2(a)(51).

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

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

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

"State" means the State of New Jersey.

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

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

Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Amended by R.2007 d.131, effective May 7, 2007.
See: 38 N.J.R. 4392(a), 39 N.J.R. 1733(a).
Added definition "Private placement form".

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

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

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

(c) The following types of contracts and forms are exempt from compliance with this subchapter:

1. Annuity contracts, other than individual contracts and synthetic guaranteed investment contracts;
2. Annuity contracts used solely for structured settlements that are purchased by an insurer or an obligor for the purpose of funding defined periodic payments pursuant to a court order or an out of court settlement of a tort liability claim, or for periodic payments in settlement of a workers compensation claim; and
3. Individual variable life forms and individual variable annuity forms sold exclusively as private placement forms.

(d) Forms drafted exclusively to meet the requirements for favorable tax treatment of a life insurance policy or annuity contract under the Internal Revenue Code of 1986, as amended (Code), are exempt from compliance with this Subchapter. Such requirements include those found in Sections 401, 403(b) and 408A, and in any similar section of the Code applicable to Federal tax treatment of life insurance policies or annuity contracts. This exemption shall not apply to any form which contains additional or optional provisions, requirements or modifications included by the insurer.

Amended by R.2001 d.408, effective November 5, 2001.

See: 33 N.J.R. 2263(a), 33 N.J.R. 3747(a).

Added (c).

Amended by R.2004 d.174, effective May 3, 2004.

See: 35 N.J.R. 4437(a), 36 N.J.R. 2197(a).

Added (d).

Amended by R.2007 d.131, effective May 7, 2007.

See: 38 N.J.R. 4392(a), 39 N.J.R. 1733(a).

Rewrote (c).

11:4-40.4 General requirements

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

1. All individual health, group health, blanket, prepaid legal contracts, group life and service corporation forms, individual life, credit life and health, mortgage guaranty, separate account, variable contract and annuity, group credit, synthetic guaranteed investment contract forms and other related correspondence pursuant to this subchapter submitted or resubmitted for approval or for file and use shall be submitted to the Department through the use of the National Association of Insurance Commissioners electronic filing system known as System for Electronic Rate and Form Filing (SERFF). As of July 19, 2010, the Office of Life and Health will no longer accept any rate or policy form filings other than through SERFF. Any such filings received after July 19, 2010 in any method other than

See: 36 N.J.R. 3940(a).
 Public Notice: Life/Health/Annuity Forms Certification Eligibility.
 See: 37 N.J.R. 3463(a).
 Public Notice: Life/Health/Annuity Forms Certification Eligibility.
 See: 38 N.J.R. 3928(a).
 Public Notice: Life/Health/Annuity Forms Certification Eligibility.
 See: 39 N.J.R. 3566(c).
 Public Notice: Life/Health/Annuity Forms Certification Eligibility.
 See: 40 N.J.R. 5294(b).
 Public Notice: Life/Health/Annuity Forms Certification Eligibility.
 See: 41 N.J.R. 3464(a).
 Public Notice: Life/Health/Annuity Forms Certification Eligibility.
 See: 42 N.J.R. 2150(b).

11:4-40.10 File and use procedures

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

1. A certification memorandum signed and acknowledged by a responsible officer of the insurer, which shall include the following:
 - i. A statement that the certification is filed pursuant to P.L. 1995, c.73, section 17;
 - ii. A statement that the responsible officer signing the certification memorandum is authorized to execute the document;
 - iii. A statement that the responsible officer signing the certification memorandum is familiar with the insurer’s filing and all laws, regulations, bulletins and published guidelines applicable to the particular type of form, and that the form complies with all laws, regulations, bulletins and published guidelines applicable to the particular type of form;
 - iv. A statement that the insurer intends for the Department to rely on the certification in accepting the filing made pursuant to this subsection;
 - v. A statement that the responsible officer signing the certification memorandum is aware of the penalties for submitting an improper certification or false filing;
 - vi. A statement that the responsible officer signing the certification memorandum has supervised and is responsible for the completion and submission to the Department of the checklist required for the particular type of form; and
 - vii. A statement that the insurer shall not use the form before receipt of the form is acknowledged by the Department.

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

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

(d) If the Commissioner determines that the form submitted to the Department by the insurer pursuant to (a)

above fails to comply with any law, or regulation, bulletin or published guideline applicable to the particular type of form, the Department shall notify the insurer in writing of the specific reasons for objecting to the form, and may disapprove the form for further use in this State.

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

1. A fine not to exceed \$50,000; and
2. A maximum penalty of \$1,000 per contract or certificate issued with a form determined to be improperly certified pursuant to this subsection.
 - i. For purposes of this subsection, an “improper certification” means a certification that provides any misrepresentation or false statement material to a certification form.

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

11:4-40.11 Service fees

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

**APPENDIX
(RESERVED)**

Repealed by R.2010 d.157, effective July 19, 2010.
 See: 41 N.J.R. 3371(a), 42 N.J.R. 1610(a).
 Appendix was “New Jersey Department of Insurance Policyform Review”.

SUBCHAPTER 40A. “40 STATES” FILE AND USE STANDARDS AND PROCEDURES

11:4-40A.1 Purpose and scope

(a) The purpose of this subchapter is to implement P.L. 2001, c.237 (N.J.S.A. 17B:25-18.4), which establishes a spe-

cial procedure whereby insurers may forego prior approval of certain life insurance, annuity and variable contract forms.

(b) This subchapter shall apply to all individual life insurance, individual annuity, group annuity, group life, variable life and variable annuity contract forms to be issued by an insurer authorized to do business in this State. This subchapter shall not apply to any health insurance policy, or contract forms or benefits, including specified disease or critical illness policies, contracts or benefits.

11:4-40A.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 all contracts meeting the definition set forth at N.J.S.A. 17B:17-5.

“Available for sale or use” means that the insurer has complied with the state’s laws, regulations, and procedures to allow the insurer to sell or use the form in that state.

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

“Department” means the Department of Banking and Insurance.

“Form,” “contract form” and “policy form” mean all annuity contract forms; all life insurance policy and contract forms; all variable contract forms; and all group insurance certificates as defined within this subchapter, including endorsements, riders and application forms.

“Health insurance” means all policies, contracts and benefits meeting the definition set forth at N.J.S.A. 17B:17-4, including specified disease and critical illness policies, contracts and benefits as defined at N.J.A.C. 11:4-53.

“Improper certification” means providing any misrepresentation or false statement material to a certification form.

“Life insurance” means all policies and contracts meeting the definition set forth at N.J.S.A. 17B:17-3.

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

“Unique product features or design” means that the contract language that expresses the methodology used to calculate values, benefits and rates is materially the same. Non-material differences include unique requirements mandated by a state’s law (for example, mandated use of a unisex mortality table); synonyms used (for example, “period” instead of “term,” “face amount” instead of “insurance

amount”); and quantitative differences of no more than 10 percent (for example, one policy contains a \$50.00 charge, while another contains a \$55.00 charge). Standard contract provisions are not considered part of the unique product feature or design.

“Variable contracts” means all contracts meeting the definition set forth at N.J.S.A. 17B:28-1 et seq.

11:4-40A.3 Eligibility

(a) Forms submitted to the Commissioner on the basis that they have been made available for sale or use in 40 states, subject to state variations that do not alter the unique features or design of the product, shall be eligible for sale or use pursuant to the requirements of this subchapter. Notwithstanding eligibility, any such form shall comply with New Jersey law regarding standard contract provisions as identified below.

1. Individual Life:

- i. Free Look as set forth in N.J.S.A. 17B:25-2.1;
- ii. Grace Period as set forth in N.J.S.A. 17B:25-3;
- iii. Incontestability as set forth in N.J.S.A. 17B:25-4, 16 and 17;
- iv. Entire Contract as set forth in N.J.S.A. 17B:25-5;
- v. Misstatement of Age as set forth in N.J.S.A. 17B:25-6;
- vi. Dividends as set forth in N.J.S.A. 17B:25-7;
- vii. Policy Loan as set forth in N.J.S.A. 17B:25-8;
- viii. Reinstatement as set forth in N.J.S.A. 17B:25-9;
- ix. Payment of Premium as set forth in N.J.S.A. 17B:25-10;
- x. Automatic Premium Loan Notice as set forth in N.J.S.A. 17B:25-10.1;
- xi. Payment of Claims as set forth in N.J.S.A. 17B:25-11;
- xii. Beneficiary as set forth in N.J.S.A. 17B:25-12;
- xiii. Nonforfeiture Benefits as set forth in N.J.S.A. 17B:25-19(a) and (l);
- xiv. Title as set forth in N.J.S.A. 17B:25-14; and
- xv. Period in Which to Commence Cause of Action as set forth in N.J.S.A. 17B:25-15;

2. Group Life:

- i. Requirements for Eligible Groups as set forth in N.J.S.A. 17B:27-1;

- ii. Dependents as set forth in N.J.S.A. 17B:27-9;
 - iii. Grace Period as set forth in N.J.S.A. 17B:27-11;
 - iv. Incontestability as set forth in N.J.S.A. 17B:27-12;
 - v. Application, Representations not Warranties, Entire Contract as set forth in N.J.S.A. 17B:27-13;
 - vi. Evidence of Insurability as set forth in N.J.S.A. 17B:27-14;
 - vii. Age Adjustments as set forth in N.J.S.A. 17B:27-15;
 - viii. Participating Policies as set forth in N.J.S.A. 17B:27-16;
 - ix. Beneficiary and Facility of Payment as set forth in N.J.S.A. 17B:27-17;
 - x. Certificates as set forth in N.J.S.A. 17B:27-18;
 - xi. Conversion as set forth in N.J.S.A. 17B:27-19 and 20;
 - xii. Death within Conversion Period as set forth in N.J.S.A. 17B:27-21;
 - xiii. Certificate to Debtors as set forth in N.J.S.A. 17B:27-22; and
 - xiv. Conversion of Debtors as set forth in N.J.S.A. 17B:27-23;
3. Individual Annuity:
- i. Standard Nonforfeiture Law as set forth in N.J.S.A. 17B:25-20(f), (l), (o) and (p);
 - ii. Misstatement of Age or Sex as set forth in N.J.A.C. 11:4-43.3(c)4; and
 - iii. Premium payments as set forth in N.J.A.C. 11:4-43.5(a); and
4. Variable Contracts:
- i. Required statements as set forth in N.J.S.A. 17B:28-4; and
 - ii. Form of contract as set forth in N.J.S.A. 17B:28-5(c) and (d), except that a periodic report that complies with N.J.A.C. 11:4-45 shall be considered to be approved by the Commissioner as required by N.J.S.A. 17B:28-5(c)(iii).
- (b) Carriers shall solicit, market, administer and service forms made available for sale or use pursuant to P.L. 2001, c.237 in accordance with all applicable New Jersey statutes and rules, including as of April 7, 2003:
- 1. Advertisement of life insurance and annuity, N.J.A.C. 11:2-23;
 - 2. Accelerated death benefit, N.J.A.C. 11:4-30;
 - 3. Fraud warning statement, N.J.S.A. 17:33A-6c;
 - 4. Funeral insurance policy, N.J.A.C. 11:4-25;
 - 5. Group coverage discontinuance and replacement, N.J.A.C. 11:2-13;
 - 6. Illustrations, N.J.A.C. 11:4-52 and N.J.S.A. 17B:28-5(b);
 - 7. Juvenile insureds, N.J.A.C. 11:4-24.4;
 - 8. Life Insurance Solicitation, N.J.A.C. 11:4-11;
 - 9. Life and Health Insurance Policy Language Simplification Act, N.J.S.A. 17B:17-17 et seq.;
 - 10. Limited Death Benefit Form, N.J.A.C. 11:4-21;
 - 11. Loan notices, N.J.A.C. 11:4-41.3(b)7;
 - 12. New Jersey Fair Credit Reporting Act, N.J.S.A. 56:11-33;
 - 13. Periodic reports, N.J.A.C. 11:4-45;
 - 14. Replacement of life insurance policy, N.J.A.C. 11:4-2;
 - 15. Standards for smoker/nonsmoker and/or tobacco/nontobacco reclassification, N.J.A.C. 11:4-41.14;
 - 16. Trade practices and discrimination, N.J.S.A. 17B:30-1 et seq.; and
 - 17. Unfair claims settlement practices, N.J.A.C. 11:2-17.

11:4-40A.4 Filing procedures

(a) Filings pursuant to N.J.A.C. 11:4-40A.3(a) shall include the following:

1. For each form submitted, a separate certification memorandum, signed by a responsible officer of the insurer, which shall include: a statement that the form has been made available for sale or use in 40 states, subject to state variations that do not alter the unique features or design of the product; the form number of the form to which it applies; and a notary signature to be shown outside of the seal.

i. The certification shall be acknowledged by a responsible officer of the insurer. The acknowledgement process shall be the same as that which applies to documents for recording instruments conveying or affecting interests in real estate in this State pursuant to N.J.S.A. 46:14-2.1 et seq.;

2. An Initial Submission Data form required by N.J.A.C. 11:4-40. The Request Type Code referred to in the Data Form shall be "40." The form shall be filled in for complete specimen issue, including any necessary schedule(s); and

3. A submittal letter, which shall specify the issue ages and intended market for the form.

(b) The Department shall acknowledge receipt of the form and a proper certification by providing the insurer with such acknowledgement within 30 days of the date transmitted.

(c) If the Department determines that the form submitted fails to satisfy all of the eligibility requirements set forth at N.J.A.C. 11:4-40A.3, the Department shall return the filing to the insurer for non-action within 30 days of the date transmitted. Additionally, if the filing fails to satisfy the filing procedures set forth in this section, the Department may return the filing to the insurer for non-action. Any return for non-action shall specify the deficiencies in the filing. Any filing returned for non-action may be resubmitted pursuant to P.L. 2001, c.237 after the identified deficiencies have been cured.

Amended by R.2010 d.157, effective July 19, 2010.
See: 41 N.J.R. 3371(a), 42 N.J.R. 1610(a).

Section was "Submission procedures". In the introductory paragraph of (a), substituted "Filings" for "Submissions"; in the introductory paragraph of (a)1, inserted a comma following "memorandum", inserted "; and a notary signature to be shown outside of the seal", and deleted "and" following "product;"; in (b), deleted "by first class mail" preceding "within" and substituted "the date transmitted" for the second occurrence of "receipt"; and in (c), substituted "filing" for "submission" throughout, and substituted "the date transmitted" for "receipt".

11:4-40A.5 Penalties

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

1. A fine not to exceed \$50,000; and
2. A maximum penalty of \$1,000 per policy issued on a form determined to be improperly certified pursuant to this subchapter.

(b) If, after notice and a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, an insurer is found by the Commissioner to be in violation of this subchapter, the form may be disapproved, and, in addition to any other penalties that may be imposed pursuant to law, the Commissioner may bar the insurer from participating in the certification process pursuant to this subchapter for a period not to exceed one year.

11:4-40A.6 Effect on previously acknowledged forms

(a) Any form and certification submitted pursuant to P.L. 2001, c.237 prior to April 7, 2003, which was acknowledged by the Commissioner but does not meet the requirements of this subchapter, shall be deemed withdrawn July 6, 2003, and the form may not be available for sale or use after that date. Forms deemed withdrawn may be resubmitted pursuant to P.L. 2001, c.237, but shall include a new form number.

(b) With respect to forms and certifications submitted pursuant to P.L. 2001, c.237 prior to April 7, 2003, which were acknowledged by the Commissioner and which do meet the requirements of this subchapter, the insurer shall submit a new certification memorandum pursuant to N.J.A.C. 11:4-40A.4(a)1 by October 4, 2003. The insurer may continue to make the previously acknowledged form available for sale or use during this period. Any condition specified in the Department's prior letter of acknowledgement which is inconsistent with this subchapter is invalidated and of no force or effect.

SUBCHAPTER 41. STANDARDS FOR INDIVIDUAL LIFE INSURANCE POLICY FORMS

11:4-41.1 Purpose and scope

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

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

11:4-41.2 Definitions

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

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

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

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

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

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

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

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

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.

(b) This subchapter shall apply to all group life, group health and blanket insurance contracts and policies delivered or issued for delivery in this State on or after April 15, 1996, including any group life, group health and blanket insurance policies and contracts the forms of which the Commissioner has determined are eligible for file and use in accordance with N.J.A.C. 11:4-40.

11:4-42.2 Definitions

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

“Blanket insurance” means a policy or contract of insurance against death or injury resulting from an accident or from accidental means otherwise in compliance with the requirements of N.J.S.A. 17B:27-32.

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

“Covered person” means any person for whom an insurer has promised to provide a benefit of pecuniary value in accordance with the terms of a contract or policy for group life, group health or blanket insurance.

“Department” means the New Jersey Department of Banking and Insurance.

“Federal plan” means a plan for benefits established in accordance with the Federal Social Security Act (OASDI), the Railroad Retirement Act, the Jones Act, or the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act.

“Group health insurance” means a contract or agreement that covers more than one person whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the bodily injury, disablement, sickness, death by accident or accidental means of a human being, or because of any expense relating thereto, or because of any expense incurred in the prevention of sickness, and includes every risk pertaining to any of the enumerated risks. The term “group health insurance” does not include workers’ com-

pensation coverage, blanket insurance or stop loss or excess risk insurance as defined at N.J.A.C. 11:4-40, but includes and is not limited to long term care, disability income protection, hospital expense, hospital confinement, medical/surgical expense and major medical expense coverages.

“Group life insurance” means a policy or contract which covers more than one person as part of a group that satisfies the specifications of N.J.S.A. 17B:27-2 through 17B:27-8, under which an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the cessation of human life. The term “group life insurance” also includes the granting of endowment benefits and optional modes of settlement of proceeds of group life insurance, as well as provisions in a group policy for: additional benefits in the event of death by accident or accidental means or in the event of dismemberment or loss of sight; or safeguarding such insurance against lapse or giving a special surrender value, or special benefit or annuity in the event that the insured shall become totally and permanently disabled, whether such provisions are incorporated in a policy or contract or supplemental thereto. The term “group life insurance” does not include worker’s compensation coverages.

“Insurer” means any person transacting or authorized to transact the business of life and/or health insurance in the State of New Jersey, including insurance companies operating pursuant to N.J.S.A. 17:17-1 et seq., or 17B:17-1 et seq.; fraternal benefit societies operating pursuant to N.J.S.A. 17:44-1 et seq.; hospital service corporations operating pursuant to N.J.S.A. 17:48-1 et seq.; medical service corporations operating pursuant to N.J.S.A. 17:48A-1 et seq.; health service corporations operating pursuant to N.J.S.A. 17:48E-1 et seq.; and any insurer operating pursuant to P.L. 1995, c.196.

“Other income,” when used in relation to offsets against group disability income benefits, means and may be defined no more restrictively by an insurer than:

1. That portion of retirement benefits and/or disability benefits provided under the employer’s plan attributable to the group policyholders or sponsoring employer’s contributions;
2. Benefits paid by Federal plans to the covered person and to those family members receiving supplementary Federal benefits as a result of the covered person’s disability where the family members reside with the covered person or the covered person has a legal obligation to provide their financial support;
3. Compensation from secondary employment obtained after the date of disability or from all secondary employment where the group policy providing disability income benefits insures employment income from all sources;

4. Expected retirement benefits and expected benefits payable by Federal plans, pursuant to the limitations set forth at N.J.A.C. 11:4-42.7(b);

5. Expected retirement benefits where the covered person is eligible for full retirement benefits under either the policyholder or sponsoring employer's retirement plan at the later of age 62 or the plan's normal retirement age, but only to the extent of expected benefits attributable to the policyholder or sponsoring employer's contributions;

6. Expected disability benefits provided under the policyholder's or sponsoring employer's retirement plan where acceptance of such benefits would not result in a reduction of the covered person's ultimate retirement benefits at the retirement plan's normal age, but, to the extent the covered person accepts such disability benefits, only that proportion of the disability benefits attributable to the policyholder's or sponsoring employer's contribution; and

7. The amount the covered person receives or is entitled to receive as disability income payments under any state compulsory benefit law.

The term "other income" does not include:

1. Cost of living increases in benefits (including cost of living increases in benefits which qualify as other income);

2. Disability income benefits provided by no-fault motor vehicle insurance;

3. Worker's compensation benefits if the group disability income policy excludes benefits for occupational injuries or illnesses;

4. Military and veteran's benefits where such benefits are paid for illnesses and injuries that were incurred prior to the date of disability or where the group disability policy excludes or limits benefits for illness or injury due to war or military activity;

5. Disability or retirement benefits provided by sources other than the group policyholder or sponsoring employer;

6. Disability or retirement benefits or other income benefits not paid in the same month as the policy's disability benefit, except as noted at N.J.A.C. 11:4-42.5;

7. Social security retirement benefits received by the covered person or members of his family which are not the direct result of the covered person's disability; and

8. Anticipated or expected benefits obtained or obtainable through legal doctrine, third party liability, subrogation, or other arrangement.

"Pre-authorization" means the processes by which insurers determine the medical necessity and/or medical appropriateness of otherwise covered treatments and procedures prior to the rendering of such treatments and procedures, including, but not limited to, pre-admission review, pre-treatment review, utilization review and case management.

"Sponsoring employer" means the employer sponsoring the retirement and/or disability plan and includes employers participating in a group insurance trust.

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

11:4-42.3 Applicability of other standards

(a) The standards contained in this subchapter shall be in addition to any other rules and statutes applicable to group health insurance, group life insurance and blanket insurance contracts, policies and certificates.

(b) If a group insurance contract, policy or certificate contains provisions typically found in individual life or health insurance policies that the Department determines appropriate for use in group policies, the Commissioner may apply the rules and statutes governing individual policies when reviewing such provisions notwithstanding that they are contained in a group contract, policy or certificate.

(c) Nothing in this subchapter shall be construed to limit the authority of the Commissioner to disapprove contracts, policies and certificates pursuant to N.J.S.A. 17B:27-25 and 17B:27-49, 17:48-8, 17:48A-9 and 17:48E-13 which, in the opinion of the Commissioner, contain provisions that are unjust, unfair, inequitable, misleading, contrary to law or to the public policy of this State.

11:4-42.4 General standards

(a) The face page of every certificate issued under a blanket insurance policy or a group policy providing health insurance or life insurance delivered or issued for delivery in New Jersey shall state that it is subject to the laws of the State of New Jersey.

(b) Group policies and certificates providing health or blanket insurance that include convalescent or extended care benefits following hospitalization shall not condition such benefits upon admission to the convalescent or extended care facility within a period of less than 14 days after discharge from the hospital.

(c) Group policies and certificates that provide disability benefits shall provide that a period of disability begins on the date that disability commences.

1. A period of disability shall not be based on the date of first medical treatment.

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

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

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

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

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

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

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

6. Medicare.

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

SUBCHAPTER 43. INDIVIDUAL ANNUITY CONTRACT FORM STANDARDS

11:4-43.1 Purpose and scope

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

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

11:4-43.2 Definitions

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

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

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

“Civil union partner” means any person who participates in a civil union as defined and established pursuant to N.J.S.A. 37:1-28 et seq. and its implementing rules.

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

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

“Department” means the New Jersey Department of Banking and Insurance.

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

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

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

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

Amended by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
Amended by R.2009 d.367, effective December 7, 2009.
See: 41 N.J.R. 72(a), 41 N.J.R. 4453(a).
Added definition “Civil union partner”.

11:4-43.3 General requirements and prohibitions

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

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

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

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

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

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

4. The form shall contain a provision describing any method for adjusting benefits and values on the basis of misstatement of age or sex. Interest may be applied in determining overpayments and underpayments at a rate specified in the form. The same specified rate shall apply to overpayments and underpayments.

(d) An insurer shall use the same form for field issue and home office issue contracts when the contract terms are written so as to make the difference in the administrative aspect of the issuance and delivery process negligible.

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.

(f) The form may contain language that permits the insurer unilaterally to amend or modify the form to satisfy any applicable law. However, the owner shall be permitted to refuse any such change unless noncompliance would cause the con-

tract to be null and void or fail to comply with New Jersey or Federal law.

(g) The form shall be amended or endorsed to reflect any changes or modifications made to the form subsequent to issue.

(h) Death benefits in individual annuities will be considered subsidiary or incidental if they satisfy one of the following conditions:

1. A death benefit equal to or less than the contract value (annuity account value or surrender value);

2. A death benefit equal to or less than a "highest periodic value" calculated for any prior period for which the contract was in force (for instance, highest contract anniversary value, highest monthly value, highest five-year value) adjusted for subsequent premiums and withdrawals. Such a death benefit provision would only be applicable to an equity-indexed, market value adjusted, or other indexed contract with the potential for increase or decrease in the annuity value;

3. A death benefit equal to or less than the greater of the contract value or the accumulation of premiums at a specified interest rate (adjusted for withdrawals), not to exceed 200 percent of premiums, such premiums to be reduced by any withdrawals;

4. A death benefit equal to or less than a percentage of the "earnings" or "gain" on the contract (defined as the contract value less premiums paid plus withdrawals), provided that the amount of the death benefit in addition to the contract value is no greater than 50 percent of the gain on the contract;

5. A death benefit based on a combination of an "accumulation" death benefit ((h)3 above) and a death benefit based upon the "gain" of the contract ((h)4 above), provided that the combined amount does not exceed the greater of the two death benefits described in (h)3 and 4 above; or

6. Any other death benefit which a qualified actuary, as defined in N.J.A.C. 11:4-47.2, certifies and demonstrates to the Department has an expected and/or maximum value that is within 25 percent of the value of a death benefit permitted by (h)1 through 5 above.

Amended by R.2000 d.130, effective March 20, 2000.

See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).

In (c), deleted a former 1, recodified former 2 through 4 as 1 through 3, and deleted a former second sentence in the new 2.

Amended by R.2001 d.410, effective November 5, 2001.

See: 33 N.J.R. 2265(a), 33 N.J.R. 3748(a).

In (c), added 4; added (f) and (g).

Amended by R.2006 d.374, effective October 16, 2006.

See: 37 N.J.R. 3543(a), 38 N.J.R. 4488(b).

Added (h).

Amended by R.2007 d.131, effective May 7, 2007.

See: 38 N.J.R. 4392(a), 39 N.J.R. 1733(a).

In (d), deleted "not" following "shall" and inserted "when the contract terms are written so as to make the difference in the administrative aspect of the issuance and delivery process negligible".

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 dollar limits on premium payments, which the insurer may waive in a uniform and nondiscriminatory manner upon written notice of any new limits to the owner. Forms shall describe the initial limits and the required written notice of any new limits. Insurers shall not arbitrarily refuse premium payments.

(b) An annuity form shall only be identified as a flexible premium annuity and use the corresponding formula for the derivation of the minimum nonforfeiture amount for a contract providing flexible considerations set forth at N.J.S.A. 17B:25-20g(1) if the owner is permitted to pay premiums for a period of no less than five years. Notwithstanding this requirement, insurers may issue individual flexible premium deferred annuities that require annuitization at a fixed age to persons who are less than five years from such fixed age. Any annuity contract providing flexible premiums for less than five years shall use the formula for derivation of the minimum nonforfeiture amount for a contract providing a single consideration set forth at N.J.S.A. 17B:25-20g(3).

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

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

(e) 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.

(f) The requirements at (e) 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.

(g) 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.

Amended by R.2001 d.410, effective November 5, 2001.
See: 33 N.J.R. 2265(a), 33 N.J.R. 3748(a).

Rewrote (a); added new (b) and recodified former (b) through (f) as (c) through (g); in (f), substituted "(e)" for "(d)" following "requirements at".

11:4-43.6 Waiver of surrender charges

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

1. The benefit shall be limited to the confinement of the owner, the annuitant, the owner's spouse or civil union partner or the annuitant's spouse or civil union partner. Confinement of any other family member not identified in the contract shall not qualify for the benefit.

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

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

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

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

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

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

value used in the calculation of the penalty free amount is determined.

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

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

In (a), deleted former 1 and 2 and recodified former 3 as 1; and in (b), deleted former 1 and 2 and recodified former 3 through 6 as 1 through 4.
Amended by R.2009 d.367, effective December 7, 2009.
See: 41 N.J.R. 72(a), 41 N.J.R. 4453(a).
Rewrote (a)1.

11:4-43.7 Surrender charges for individual deferred annuities

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

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

SUBCHAPTER 44. STANDARDS FOR CONTRACTS ON A VARIABLE BASIS

11:4-44.1 Purpose and scope

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

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

11:4-44.2 Definitions

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

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

“Contract on a variable basis” or “variable contract” means any separate account contract providing for the dollar amount of life insurance or annuity benefits or other contractual payments or values thereunder to vary so as to reflect investment results of one or more separate accounts in which amounts

with respect to any such contracts have been placed. Market value adjusted annuities are included within this definition, and are not fixed annuities.

“Department” means the New Jersey Department of Banking and Insurance.

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

Amended by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
Amended by R.2003 d.54, effective February 3, 2003.
See: 34 N.J.R. 3194(a), 35 N.J.R. 618(a).
Deleted “Market value adjusted annuity”.

11:4-44.3 Standards for variable contracts

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

1. A provision describing the periodic reports;
2. A provision specifying any rights for deferral. Any deferral of a minimum guaranteed death benefit for an individual variable life insurance contract shall comply with N.J.S.A. 17B:25-11; and
3. A provision describing any conditions for partial withdrawals, partial surrenders, loans, transfers and new deposits. Any required minimum amount for a partial withdrawal, partial surrender, loan or transfer shall not exceed \$1,000.

(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) All individual life insurance contracts on a variable basis shall include a period of free review as described at N.J.A.C. 11:4-41.3(b)1. The amount to be returned to the policyholder following cancellation of the contract pursuant to this subsection shall be no less than premiums (including fees and charges) applied to the separate account, adjusted for investment gains and losses, plus premiums (including fees and charges) applied to any general account option.

(d) 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.

(e) Death benefits in annuity contracts issued on a variable basis will be considered subsidiary or incidental if they satisfy one of the following conditions:

1. A death benefit equal to or less than the contract value (annuity account value or surrender value);
2. A death benefit equal to or less than a "highest periodic value" calculated for any prior period for which the contract was in force (for instance, highest contract anniversary value, highest monthly value, highest five-year value) adjusted for subsequent premiums and withdrawals;
3. A death benefit equal to or less than the greater of the contract value or the accumulation of premiums at a specified interest rate (adjusted for withdrawals) not to exceed 200 percent of premiums, such premiums to be reduced by withdrawals;
4. A death benefit equal to or less than a percentage of the "earnings" or "gain" on the contract (defined as the contract value less premiums paid plus withdrawals), provided that the amount of the death benefit in addition to the contract value is no greater than 50 percent of the gain on the contract;
5. A death benefit based on a combination of an "accumulation" death benefit ((e)3 above) and a death benefit based upon the "gain" of the contract ((e)4 above), provided that the combined amount does not exceed the greater of the two death benefits described in (e)3 and 4 above;
6. Any other death benefit which a qualified actuary, as defined in N.J.A.C. 11:4-47.2, certifies and demonstrates to the Department has an expected and/or maximum value that is within 25 percent of the value of a death benefit permitted by (e)1 through 5 above.

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

In (a), deleted a former 1, recodified former 2 through 4 as 1 through 3, and substituted "\$1,000" for "\$500.00" at the end of the second sentence in the new 3.

Amended by R.2001 d.410, effective November 5, 2001.

See: 33 N.J.R. 2265(a), 33 N.J.R. 3748(a).

In (a), rewrote 2 and 3; added new (c) and recodified former (c) as (d).
Amended by R.2006 d.374, effective October 16, 2006.

See: 37 N.J.R. 3543(a), 38 N.J.R. 4488(b).

Added (e).

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 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.

Amended by R.2001 d.410, effective November 5, 2001.

See: 33 N.J.R. 2265(a), 33 N.J.R. 3748(a).

In (a), deleted former 3 and recodified former 4 as 3.

11:4-44.5 (Reserved)

Repealed by R.2003 d.54, effective February 3, 2003.

See: 34 N.J.R. 3194(a), 35 N.J.R. 618(a).

Section was "Standards for individual market value adjusted annuities".

SUBCHAPTER 45. PERIODIC REPORTS

“Flexible factors” means premiums, premium factors (for example, interest credits, mortality charges, or expense charges) or benefits (for example, death benefits, cash or surrender values) or benefit charges (for example, surrender charges) that the insurer reserves the right to modify, subject to a flexible-factor guarantee, on the basis of future anticipated or emerging experience. Flexible factors do not include: interest or investment credits based on an external index, investment increments based on performance of assets in a variable account contract, the mortality and expense risk charge deducted in determining the investment return on a separate account, or dividends based on the principle of distributable surplus.

“Flexible-factor form” means any life insurance policy, rider or endorsement, whether participating or nonparticipating, where the insurer reserves the right to modify one or more flexible factors as defined in this section. The right to modify is subject to a flexible-factor guarantee and the modification must be based upon future anticipated or emerging experience.

“Flexible-factor guarantee” means a statement in the contract which guarantees the upper or lower limits of specific flexible factors.

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

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

Amended by R.1997 d.444, effective October 20, 1997.

See: 29 N.J.R. 3409(a), 29 N.J.R. 4459(c).

Amended “Qualified actuary”.

Amended by R.2001 d.7, effective January 2, 2001.

See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

Amended by R.2001 d.411, effective November 5, 2001.

See: 33 N.J.R. 2268(a), 33 N.J.R. 3749(a).

Added “Experience factors” and “Flexible factors” and deleted “Tiered factors”.

Amended by R.2003 d.278, effective July 7, 2003.

See: 35 N.J.R. 497(a), 35 N.J.R. 2897(a).

Amended “Experience factors”, “Flexible factors”, and “Flexible-factor form”; added “Flexible-factor guarantee”; deleted “Minimum guarantee premium” and “Persistency bonus”.

11:4-47.3 General requirements

(a) All forms with any flexible factors shall include a flexible-factor guarantee.

(b) All forms to which this subchapter applies shall specify the experience factors upon which changes to flexible factors could be based.

Amended by R.2001 d.411, effective November 5, 2001.

See: 33 N.J.R. 2268(a), 33 N.J.R. 3749(a).

Designated existing paragraph as (a) and added (b).

Amended by R.2003 d.278, effective July 7, 2003.

See: 35 N.J.R. 497(a), 35 N.J.R. 2897(a).

Rewrote (a).

11:4-47.4 Modification of flexible factors

(a) Any modification to flexible factors on an in-force policy made by an insurer shall be subject to the following requirements:

1. The modification shall be made only to flexible factors identified as such in the contract;
2. The modification shall be based upon future anticipated or emerging experience and on experience factors only as identified in the contract; and
3. The modification shall be made to all individuals of the same class or equal expectation of life in compliance with the requirements of N.J.S.A. 17B:30-12c.

(b) Any modification to flexible factors shall not result in the distribution of prior profits or the recovery of prior losses.

Repeal and New Rule, R.2003 d.278, effective July 7, 2003.

See: 35 N.J.R. 497(a), 35 N.J.R. 2897(a).

Section was “Pricing assumption-actuarial certification”.

11:4-47.5 Nonforfeiture benefits—actuarial certification

(a) Each form submitted for filing shall be accompanied by a certification by a qualified actuary that the nonforfeiture benefits provided are in compliance with N.J.S.A. 17B:25-19 or are exempt from providing guaranteed nonforfeiture benefits as described in N.J.S.A. 17B:25-19.

1. Nonforfeiture compliance for supplementary term insurance benefits that create a “target” death benefit based upon the combined coverage provided by the base policy forms and supplementary benefit shall be based upon the total coverage provided by the base plan and supplementary benefit combination.

2. All other term insurance benefits shall be tested for nonforfeiture compliance as stand-alone insurance coverage.

(b) For forms where the principal variable is the insurer’s right to change (either increase or decrease) premiums subject to a maximum premium amount, policy provisions relating to nonforfeiture shall satisfy the requirements set forth in N.J.S.A. 17B:25-19. For purposes of determining compliance with this statute, “premiums specified in the policy” shall mean the initial scale, rather than the maximum scale, of guaranteed premiums, unless the latter would produce larger cash values. In this case, the minimum nonforfeiture benefits shall be based on the assumption that guaranteed maximum premiums shall apply wherever possible.

(c) For policies where cash values are determined retrospectively as an accumulation of gross premiums less expense charges, with interest increments and mortality decrements, the excess of expense charges in the first policy year over renewal expense charges may not be greater than the maximum initial expense allowance as set forth in N.J.S.A. 17B:25-19h(i).

(d) Policy forms may incorporate surrender charges of specified amounts at specified durations, provided that the resulting cash values are at least as large as those developed under (c) above assuming the maximum initial expense allowance and no surrender charges. A form shall be considered to satisfy this requirement if the surrender charges are less than the unamortized unused initial first year expense allowance. The initial expense allowance shall be amortized over the period for which coverage was purchased.

Amended by R.1997 d.444, effective October 20, 1997.
See: 29 N.J.R. 3409(a), 29 N.J.R. 4459(c).

Rewrote (c) as (c) and (c)1; recodified (c)1 through (c)3 as (c)1i through (c)1iii; inserted new (c)2; in (g), substituted "certification" for "memorandum", and deleted "company officer or" preceding "qualified actuary"; and added (g)1 and (g)2.

Amended by R.2001 d.411, effective November 5, 2001.
See: 33 N.J.R. 2268(a), 33 N.J.R. 3749(a).

Rewrote section.

Amended by R.2003 d.278, effective July 7, 2003.
See: 35 N.J.R. 497(a), 35 N.J.R. 2897(a).

Rewrote the section.

11:4-47.6 Penalties

Failure to comply with this subchapter shall result in the imposition of any penalties as may be authorized by law.

Recodified from N.J.A.C. 11:4-47.7 and amended by R.2003 d.278, effective July 7, 2003.

See: 35 N.J.R. 497(a), 35 N.J.R. 2897(a).

Deleted "disapproval of any flexible-factor form for delivery in this State, as well as" preceding "imposition", and deleted "other" preceding "penalties". Former N.J.A.C. 11:4-47.6, Recordkeeping, repealed.

APPENDIX (RESERVED)

Repealed by R.2003 d.278, effective July 7, 2003.
See: 35 N.J.R. 497(a), 35 N.J.R. 2897(a)

SUBCHAPTER 48. UNFAIR DISCRIMINATION

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 Banking and Insurance.

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

"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.

Amended by R.2000 d.130, effective March 20, 2000.

See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).

Amended by R.2003 d.54, effective February 3, 2003.

See: 34 N.J.R. 3194(a), 35 N.J.R. 618(a).

Deleted "Persistency bonus".

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.