CHAPTER 4

ACTUARIAL SERVICES

Authority

N.J.S.A. 17:1C–6e.

Source and Effective Date

R.2001 d.7, effective November 30, 2000.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

Executive Order No. 66(1978) Expiration Date

Chapter 4, Actuarial Services, expires on November 30, 2005.

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Subchapter 2, Replacement of Life Insurance Policy, was repealed and Subchapter 2, Replacement of Life Insurance Policy, was adopted as new rules by R.1982 d.16, effective February 1, 1982, operative June 1, 1982.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

Pursuant to Executive Order No. 66(1978), Chapter 4, Actuarial Services, was readopted as R.2001 d.7, effective November 30, 2000, and Subchapter 27, Reporting Liquor Law Liability Loss Experience Statistics, was repealed by R.2001 d.7, effective January 2, 2001. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. (RESERVED)

SUBCHAPTER 2. REPLACEMENT OF LIFE INSURANCE POLICY

11:4–2.1 Purpose

(a) The purpose of this subchapter is:

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

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

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

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

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

11:4–2.2 Definitions

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

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

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

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

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

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

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

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

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

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

4. Reissued with any reduction in cash value; or

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

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

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

11:4–2.3 Exemptions

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

1. Annuities;

2. Individual credit life insurance;

3. Group life insurance, group credit life insurance, and life insurance policies issued in connection with a pension, profit-sharing or other benefit plan qualifying for tax deductibility of premiums, provided, however, that as to any plan described in this subsection, full and complete disclosure of all material facts shall be given to the administrator of any plan to be replaced;

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

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

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

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

11:4–2.4 Duties of agent

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

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

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.)

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling service.

(Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.)

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare generally pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling service.

(Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.)

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Amended by R.1991 d.121, effective March 4, 1992.
See: 22 N.J.R. 771(a), 23 N.J.R. 690(e).
Amended Appendix text throughout in order to update and clarify changes in Medicare and secondary insurance coverage. Reorganized appendix into Exhibits A through C, with Exhibit C adding new text. Deleted information insert, "Information Concerning Changes to the Medicare Program Effective January 1, 1989," because it is obsolete.
Amended by R.1993 d.26, effective January 4, 1993.
See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).
APPENDIX substantially revised.
Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).
Exhibits A and B, repealed.
Amended by R.1996 d.295, effective July 1, 1996.
See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).
Amended by R.1999 d.161, effective May 17, 1999.
See: 31 N.J.R. 713(a), 31 N.J.R. 1336(a).

SUBCHAPTER 23A. MEDICARE SUPPLEMENT—UNDER 50 COVERAGE

Authority

N.J.S.A. 17:1C–6(e), 17:1–8.1 and P.L.1995, c.229.

Source and Effective Date

R.1996 d.195, effective April 15, 1996.
See: 27 N.J.R. 3719(a), 28 N.J.R. 1987(a).

11:4–23A.1 Purpose and scope

(a) The purpose of this subchapter is to establish a mechanism to provide Plan C coverage of the standardized Medicare supplement plans to persons under 50 years of age residing in this State who are enrolled in Medicare due to disability, or due to end stage renal disease.

(b) Except when inconsistent with a provision of this subchapter, the provisions of N.J.A.C. 11:4–23 shall apply.

Amended by R.1997 d.61, effective February 3, 1997.
See: 28 N.J.R. 4705(b), 29 N.J.R. 446(a).
At the end of (a), deleted ", until they reach the age of 65".

11:4–23A.2 Definitions

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

"Applicant" means an individual who, at the time of application to the Under 50 Plan, has not attained the age of 50 years. In the event that an applicant for Under 50 Plan coverage is disqualified solely because of age, the date of application to the Under 50 Plan shall be deemed to apply to any application for coverage pursuant to N.J.A.C. 11:4–23B.

"Commissioner" means the Commissioner of the Department of Insurance.

"Contracting carrier" means an insurer selected and appointed to service the Under 50 Plan in accordance with its plan of operation.

"Financially impaired" means an insurer or HMO which, after August 16, 1995, is not insolvent, but is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations, or an insurer or HMO which is under an order of liquidation, rehabilitation or conservation by a court of competent jurisdiction.

"Health benefits plan" means a hospital and medical expense insurance policy, hospital service corporation contract, medical service corporation contract or health service corporation contract delivered or issued for delivery in this State or a health maintenance organization subscriber contract delivered or issued for delivery in this State.

"HealthStart Plus" means the program providing coverage to pregnant women and infants up to one year of age who are in families with incomes between 185 percent and 300 percent of the poverty level, established pursuant to the Health Care Cost Reduction Act, P.L. 1991, c.187, section 25 (N.J.S.A. 26:2H–18.47).

"HMO" means a health maintenance organization authorized in accordance with N.J.S.A. 26:2J–1 et seq.

"Insurer" means an insurance company or hospital, medical or health service corporation authorized to issue health benefits plans in this State.

"Medicaid" means the program administered by the New Jersey Division of Medical Assistance and Health Services Program in the New Jersey Department of Human Services, providing medical assistance to qualified applicants, in accordance with P.L. 1968, c.413 (N.J.S.A. 30:4D–1 et seq.) and amendments thereto.

"Net earned premium" means the premium earned in New Jersey or health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plans. "Net earned premium" shall include the aggregate premiums earned in the insurer's insured group and individual business and HMO business, including premiums from contracts covering Medicaid and HealthStart Plus recipients and premiums from Medicare cost and risk contracts. "Net earned premium" shall not include premiums from any stop loss or excess coverage to the extent that such coverage:

1. Is issued to self-funded arrangements to reimburse only the self-funded arrangements for expenses exceeding per person or aggregate limits, and for which employees or other individuals are not third party beneficiaries under the policy; and

2. The per person limit is no less than $20,000 per year, and additionally, or in the alternative, the aggregate limit is no less than 125 percent of expected claims.

"Net loss of the contracting carrier" means net earned premiums and any investment income thereon less the amount in claims and reasonable administrative expenses of the contracting carrier paid in the preceding calendar year.

"Net loss of the Under 50 Plan" means the net loss of the contracting carrier plus any administrative expenses of the governing board and any other associated administrative expenses.

"Reasonable administrative expenses of the contracting carrier" means actual expenses or the expense allowance, but in no event shall the administrative expenses exceed 25 percent of premium.

"Resident" means a person whose primary residence for the majority of a year is in the State of New Jersey.

Amended by R.1997 d.61, effective February 3, 1997.
See: 28 N.J.R. 4705(b), 29 N.J.R. 446(a).
Added "Resident" and amended "Net earned premium".

11:4–23A.3 Creation of Medicare Supplement—Under 50 Coverage Plan

(a) There is created in the State of New Jersey a plan to provide Medicare Supplement Plan C coverage of the standardized Medicare supplement plans to New Jersey residents under 50 years of age who are enrolled in Medicare due to disability or due to end stage renal disease to be known as the Medicare Supplement—Under 50 Plan ("Under 50 Plan").

(b) The Under 50 Plan shall be administered by a governing board appointed pursuant to this subchapter and a plan of operation adopted by the governing board and approved by the Commissioner.

(c) Any administrative office of the governing board of the Under 50 Plan shall be located within the State of New Jersey and all meetings of the governing board shall take place in New Jersey. The contracting carrier shall at all times maintain an office and records relating to the Under 50 Plan in the State of New Jersey.

(d) Coverage by the Under 50 Plan shall be provided through a contracting carrier appointed pursuant to this subchapter and the approved plan of operation.

(e) Annually, no later than 120 days after December 31st, the governing board of the Under 50 Plan shall submit to the Commissioner a financial report in a form approved by the Commissioner and an operational report of its activities during the preceding calendar year.

Amended by R.1997 d.61, effective February 3, 1997.
See: 28 N.J.R. 4705(b), 29 N.J.R. 446(a).
In (a), deleted ", until they reach the age of 65," following "residents under 50 years of age".

11:4–23A.4 Governing board

(a) The Under 50 Plan shall be administered by a governing board composed of eight directors, one of whom shall be the Commissioner or the Commissioner's designee, one of whom shall be the contracting carrier upon its selection and appointment by the governing board, and six of whom shall be appointed by the Commissioner as follows:

1. Two directors shall be insurers writing Medicare Supplement insurance coverage in this State;

2. One director shall be an HMO nominated by the New Jersey Association of Health Maintenance Organizations;

3. One director shall be an insurer nominated by the Health Insurance Association of America; and

4. Two directors shall be members of the public who are knowledgeable about Medicare Supplement coverages, but who are not employed by or otherwise affiliated with insurers, health maintenance organizations, insurance producers, or other entities of the insurance industry.

(b) No insurer or HMO, its affiliates or subsidiaries shall serve in more than one director position on the governing board at the same time.

(c) The Commissioner, or the Commissioner's designated representative, shall sit ex-officio, and shall be a non-voting member of the governing board.

(d) The initial directors appointed to the governing board pursuant to this subchapter shall serve for staggered terms of one or two years, as determined by the Commissioner, or until successors are appointed. Thereafter, all directors of the governing board shall serve for two years or until a successor is appointed.

(e) Each director, other than the two directors who are members of the public, shall designate a primary and an alternate representative to serve on the governing board.

(f) Directors shall serve without compensation but directors who are members of the public may be reimbursed for reasonable expenses as set forth in the plan of operation.

(g) All meetings of the governing board shall be conducted in accordance with this subchapter and the approved plan of operation.

(h) The governing board shall have the power and duty to:

1. Develop and submit to the Commissioner for approval a plan of operation;

2. Establish minimum requirements and performance standards for the contracting carrier, which shall include evidence of prior experience in providing and servicing standardized Medicare supplement insurance policies or contracts in this State;

3. Establish procedures to select an auditor to review the operations of the contracting carrier relating to the Under 50 Plan;

4. Review the auditor's report and implement any recommendations determined to be appropriate;

5. Retain appropriate actuarial, accountant, or other employees, professionals and contractors as necessary to provide technical assistance in the operation of the Under 50 Plan; and

6. Perform such other functions as may be necessary and proper in accordance with this subchapter and the approved plan of operation.

11:4–23A.5 Plan of operation

(a) The plan of operation shall provide for the fair, reasonable and equitable administration of the Under 50 Plan and shall include:

1. The internal organization and proceedings of the governing board;

2. A detailed explanation, with supporting documentation, of the projected effect that fulfillment of the obligation would have on the immediate and long term financial condition of the applicant unless relief is granted as requested;

3. The most recent financial examination report, whether conducted by the applicant's state of domicile or another state;

4. A statement addressing whether the applicant is planning to modify its method of doing business in any way including, but not limited to, new acquisitions or new restructuring;

5. If the applicant is a member of a holding company system, the following shall be provided:

i. A list of all members of the holding company system;

ii. A list of all intercompany transactions for the period beginning January 1 in the year of the filing to the date of the quarterly statement immediately preceding the date of filing, in the format set forth in the statutory annual statement filed by the applicant; and

iii. A copy of the applicant's organizational chart;

6. An actuarial opinion attesting to the adequacy of reserves specifically for all accident and health lines of business, and for all lines of business which the applicant transacts, in the format of and satisfying all requirements for the actuarial opinion and memorandum required to be submitted as a part of the annual statement filed by the applicant;

i. If the applicant is an HMO, the applicant shall obtain and file an actuarial opinion which complies with the requirements set forth in (f)6 above;

7. A report signed by the attesting actuary referred to in (f)6 above, which includes, in summary form if necessary, all data utilized, a complete explanation of methods and assumptions and sufficient additional narrative to account for any features of the data or circumstances necessary for proper interpretation;

8. A copy of the annual statement of the applicant, including all accompanying exhibits, filed with this State immediately preceding the date of the relief filing;

9. Copies of all quarterly statements for the period beginning January 1 in the year of the filing to the quarterly statement immediately preceding the date of the filing;

10. A description of any relief from obligations imposed by this State or any other state granted or in effect within the preceding 12 months, and the basis upon which such relief was granted; and

11. Any other information the Commissioner may deem relevant to the consideration of the request.

(g) All data or information contained in the request for relief filed pursuant to this section shall be confidential and not be subject to public disclosure or copying pursuant to the "Right to Know" law, N.J.S.A. 47:1A–1 et seq., except for the following, but only upon written, specified request and following 10 days' written notice by the Department to the applicant:

1. N.J.A.C. 11:4–23A.12(f)1i and ii—cover letter with name of applicant and describing relief sought;

2. N.J.A.C. 11:4–23A.12(f)1iv—name, title, telephone number and telefax number of person familiar with the filing;

3. N.J.A.C. 11:4–23A.12(f)3—most recent financial examination information report;

4. N.J.A.C. 11:4–23A.12(f)5i and ii—list of members of holding company system and intercompany transactions for period preceding date of filing;

5. N.J.A.C. 11:4–23A.12(f)8—annual statement filed immediately preceding date of filing; and

6. N.J.A.C. 11:4–23A.12(f)11—additional information required by the Commissioner to evaluate a particular filing.

(h) When the Commissioner determines pursuant to section 4 of P.L. 1995, c.229, that the applicant is or would be placed in a financially impaired condition through imposition of an assessment obligation, the Commissioner shall notify the applicant that its duty to fulfill the applicable obligation shall be waived, or deferred in whole or in part, as appropriate.

(i) The Commissioner shall find that an applicant is or would be financially impaired if:

1. The applicant has been placed in rehabilitation or conservation pursuant to N.J.S.A. 17B:32–31 et seq., or such similar law of the applicant's state of domicile;

2. The Commissioner finds that the applicant is in hazardous financial condition, as determined pursuant to N.J.A.C. 11:2–27; or

3. The Commissioner finds that fulfillment of the obligation from which relief is sought would place the applicant in a hazardous financial condition, as determined pursuant to N.J.A.C. 11:2–27.

(j) If the Commissioner denies an applicant's request for relief made pursuant to this section, or if the applicant objects to the terms of the relief granted, the applicant may request a hearing on the Commissioner's determination within seven days from the date of receipt of such decision as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, and daytime telephone number of a contact person familiar with the matter;

ii. A copy of the Commissioner's determination;

iii. A statement requesting a hearing; and

iv. A concise statement describing the basis for which the applicant believes that the Commissioner's findings of fact are erroneous.

2. The Commissioner may, after receipt of a properly completed request for a hearing, provide for an informal conference between the applicant and such personnel of the Department as the Commissioner may direct, to determine whether there are material issues of fact in dispute.

3. The Commissioner shall, within 30 days of a properly completed request for a hearing, determine whether the matter constitutes a contested case, pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq.

i. If the Commissioner finds that the matter constitutes a contested case, the Commissioner shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

ii. In a matter which has been determined to be a contested case, if the Commissioner finds that there are no good-faith disputed issues of material facts and the matter may be decided on the documents filed, the Commissioner may notify the applicant in writing as to the final disposition of the matter.

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

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), and P.L.1995, c.229.

Source and Effective Date

R.1996 d.195, effective April 15, 1996.
See: 27 N.J.R. 3719(a), 28 N.J.R. 1987(a).

11:4–23B.1 Purpose and scope

(a) Every insurer issuing or renewing standardized Medicare supplement insurance policies or contracts in this State shall offer, at a minimum, Medicare Supplement Plan C policies or contracts to New Jersey residents 50 years of age or older who are enrolled in Medicare due to disability or due to end stage renal disease, except that:

1. An insurer that does not currently issue or renew individual standardized Medicare supplement insurance policies or contracts and does issue or renew standardized Medicare supplement insurance policies or contracts for groups whose membership in the group is not based on health status, claims experience, receipt of health care or medical condition, shall not be required to provide coverage, other than to members of the group.

2. No group to which the provisions of (a)1 apply shall institute an age requirement for participation in the group on or after June 1, 1995.

(b) Except when inconsistent with a provision of this subchapter, the provisions of N.J.A.C. 11:4–23 shall apply.

11:4–23B.2 Definitions

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

"Applicant" means an individual who, at the time of application to an insurer, has attained the age of 50 years but not attained the age of 65 years. In the event that an applicant for coverage pursuant to this subchapter is disqualified solely because of age, the date of the original application to the insurer shall be deemed to apply to any application for Under 50 Plan coverage pursuant to N.J.A.C. 11:4–23A where the individual under 50 years of age, or to any application pursuant to N.J.A.C. 11:4–23 where the individual is 65 years of age or older.

"Health benefits plan" means a hospital and medical expense insurance policy, hospital service corporation contract, medical service corporation contract or health service corporation contract delivered or issued for delivery in this State or a health maintenance organization subscriber contract delivered or issued for delivery in this State.

"Insurer" means an insurance company or hospital, medical or health service corporation authorized to issue health benefits plans in this State.

11:4–23B.3 Open enrollment

(a) No insurer shall deny or condition the issuance or renewal, or discriminate in the pricing of Medicare supplement policies or contracts available pursuant to section 2 of P.L. 1995, c.229 because of the health status, claims experience, receipt of health care or medical condition of an applicant if the application for a policy or contract is submitted during the six-month period beginning with the first month in which an individual is enrolled for benefits under Medicare Part B or if the application is submitted within six months of August 16, 1995.

(b) Nothing in (a) above shall be construed to prohibit the exclusion of benefits under a policy or contract during the first three months, based on a preexisting condition for which the insured received treatment or was otherwise diagnosed during the six months before the policy or contract became effective, except that this limitation shall not apply to an individual who has, under a prior health benefits policy or contract, with no intervening lapse in coverage, been treated or diagnosed for a condition under that policy or contract or satisfied a three month preexisting condition limitation.

11:4–23B.4 Rates

Rates for Medicare supplement insurance policies or contracts issued pursuant to section 2 of P.L. 1995, c.229 shall be no greater than the lowest rate charged by the insurer for the same type of policies or contracts issued to persons 65 years of age or older and shall be calculated and filed in accordance with N.J.A.C. 11:4–23.11 and 23.12.

SUBCHAPTER 24. SMOKER AND NONSMOKER MORTALITY TABLES

11:4–24.1 Purpose

The purpose of this subchapter is to authorize the use of mortality tables adopted after September 11, 1981 by the National Association of Insurance Commissioners in determining minimum nonforfeiture standards and minimum valuation standards.

11:4–24.2 Definitions

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

"1980 CSO Table" means that mortality table, consisting of separate rates of mortality for male and female lives, prescribed by N.J.S.A. 17B:19–8a(i) and N.J.S.A. 17B:25–19h(viii) and referred to therein as the Commissioners 1980 Standard Ordinary Mortality Table, with or without Ten Year Mortality Factors.

"1980 CET Table" means that mortality table, consisting of separate rates of mortality for male and female lives, prescribed by N.J.S.A. 17B:25–19h(viii) and referred to therein as the Commissioners 1980 Extended Term Insurance Table.

"1958 CSO Table" means that mortality table prescribed by N.J.S.A. 17B:9–8a(i) and N.J.S.A. 17B:25–19g and referred to therein as the Commissioners 1958 Standard Ordinary Mortality Table.

"1958 CET Table" means that mortality table prescribed by N.J.S.A. 17B:25–19g and referred to therein as the Commissioners 1958 Extended Term Insurance Table.

"Composite mortality tables" means the 1980 CSO, 1980 CET, 1958 CSO and 1958 CET mortality tables defined above, as they were originally published with rates of mortality that do not distinguish between smokers and nonsmokers.

"Juvenile" means a person or persons under 15 years of age.

"Smoker and nonsmoker mortality tables" means the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the 1980 CSO, 1980 CET, 1958 CSO and 1958 CET tables defined above and approved by the National Association of Insurance Commissioners in December 1983.

Amended by R.1996 d.81, effective February 20, 1996.
See: 27 N.J.R. 3723(a), 28 N.J.R. 1214(a).
Added "Juvenile".

11:4–24.3 Smoker and nonsmoker mortality tables

(a) In determining minimum cash surrender values, minimum amounts and minimum periods of nonforfeiture benefits for any policy of insurance delivered or issued for delivery in this State after the operative date of N.J.S.A. 17B:25–19h(xi) for that policy form and before January 1, 1989 and in determining the minimum reserve liabilities for any policy of insurance delivered or issued for delivery after the operative date of N.J.S.A. 17B:25–19h(xi) for that policy form and prior to January 1, 1989, at the option of the insurer and subject to the conditions in (e) below, the following tables may be substituted:

1. The 1958 CSO Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CSO Table; and

2. The 1958 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table.

(b) For any category of insurance issued on female lives using 1958 CSO or 1958 CET Smoker and Nonsmoker Mortality Tables in determining minimum cash surrender values, minimum amounts and minimum periods of nonforfeiture benefits, and minimum reserve liabilities, such minimum values may be calculated according to an age not more than six years younger than the actual age of the insured.

(c) Once an election has been made to use a 1980 CSO Mortality Table for a plan of insurance, the substitution in (a) above shall not be available for any subsequent new plan of insurance.

(d) In determining minimum cash surrender values, minimum amounts and minimum periods of nonforfeiture benefits for any policy of insurance delivered or issued for delivery in this State after the operative date of N.J.S.A.

17B:25–19h(xi) for that policy and in determining the minimum reserve liabilities for any policy of insurance delivered or issued for delivery after the operative date of N.J.S.A. 17B:25–19h(xi) for that policy, at the option of the insurer and subject to the conditions in (e) below, the following tables may be substituted:

1. The 1980 CSO Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CSO Table; and

2. The 1980 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Tables.

(e) For each policy form with separate rates for smoker and nonsmoker, an insurer may:

1. Use composite mortality tables to determine minimum cash surrender values, minimum amounts and minimum periods of nonforfeiture benefits and minimum reserve liabilities;

2. Use smoker and nonsmoker mortality tables to determine the valuation net premiums and minimum reserves, if any, required by N.J.S.A. 17B:19–8e and use composite minimum amounts and minimum periods of nonforfeiture benefits and basic minimum reserve liabilities; or

3. Use smoker and nonsmoker mortality tables to determine minimum cash surrender values, minimum amounts and minimum periods of nonforfeiture benefits and minimum reserve liabilities.

Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
In (a) and (d), rewrote the introductory paragraphs.

11:4–24.4 Juvenile insureds

(a) Because the smoker and nonsmoker mortality tables do not extend below age 15, the Department shall permit the following uses of the composite and smoker and nonsmoker mortality tables for juvenile insureds, as hereafter provided:

1. Insurers may use the composite mortality table for juvenile issues and continue to use such table for all future attained ages; or

2. Insurers may use the composite mortality table for juvenile issues and change to use of a smoker and nonsmoker mortality table when the insured's attained age is a specified age between 15 and 23. The insurer shall classify the insured as a nonsmoker upon the insured's reaching such attained age unless the insured is notified in writing of his or her option to elect smoker or nonsmoker status at least 30 days prior to the effective date of the change in mortality tables and the insured fails to elect smoker status.

3. Insurers may use a reasonable extrapolation of the smoker and nonsmoker mortality tables for ages 15 and below. The submission shall include an actuarial memorandum which describes the basis for the extrapolation.

(b) Insurers may classify a juvenile as a smoker only if, at the time of the application, the juvenile responds to a smoking question in the affirmative.

1. Insurers may contest the response to the question concerning smoking status only if the contract specifically reserves such right, there is an entire contract provision in the policy which states that the application for the change in smoking status is attached to and made a part of the policy and the submission describes the settlement payable upon a successful contest. A contest shall be limited to the amount of coverage which is purchased by the difference between the smoker and nonsmoker rates.

2. If the insurer intends to waive the right to contest, the submission should include a statement *to that effect* from a company officer.

(c) The policy must accurately describe all mortality tables used as composite, smoker and nonsmoker, or extrapolation for all ages.

(d) In fixed premium contracts, a change in smoker/nonsmoker classification pursuant to (a)2 above shall affect premium rates only and not the guaranteed nonforfeiture benefits. A fixed premium contract which provides for changes in smoker/nonsmoker classification pursuant to (a)2 above shall specify the guaranteed maximum smoker and nonsmoker premium and the insurer shall charge the guaranteed maximum nonsmoker premium at the attained age unless the insurer notifies the insured of his or her option to elect smoker or nonsmoker status at least 30 days prior to the effective date of the change in classification and the insured fails to elect smoker status.

New Rule, R.1996 d.81, effective February 20, 1996.
See: 27 N.J.R. 3723(a), 28 N.J.R. 1214(a).

11:4–24.5 Separability

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

Recodified from 11:4–24.4 by R.1996 d.81, effective February 20, 1996.
See: 27 N.J.R.3723(a), 28 N.J.R.1214(a).

SUBCHAPTER 25. FUNERAL INSURANCE POLICIES

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e) and 17B:17–5.1d.

Source and Effective Date

R.1996 d.328, effective July 15, 1996.
See: 28 N.J.R. 1656(a), 28 N.J.R. 3671(a).

APPENDIX B

NJ DEPARTMENT OF BANKING AND INSURANCE
TERM LIFE QUESTIONNAIRE

PLEASE PROVIDE PREMIUM RATES FOR A $100,000 FACE AMOUNT, ANNUAL, RENEWABLE, CONVERTIBLE TERM LIFE POLICY FOR THE *SIXTH* POLICY YEAR. RATES SHOULD INCLUDE EXPENSE CHARGES AND REFLECT THE EXACT PREMIUM AS PAID BY A CONSUMER. DO NOT LIST RATES PER $1,000.

ISSUE AGE	UNDER-WRITING	MALE STANDARD Premium	MALE STANDARD Dividend	FEMALE STANDARD Premium	FEMALE STANDARD Dividend
25					
35					
45					
50					

PLEASE ANSWER BY USING APPROPRIATE LETTER

(A) MEDICAL EXAM _____

(B) QUESTIONNAIRE _____

(C) OTHER, EXPLAIN _____

PLEASE RETURN TO:

OFFICE OF PUBLIC AFFAIRS

NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE

PO BOX 325

TRENTON, NJ 08625–0325

Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).
Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

APPENDIX C

NJ DEPARTMENT OF BANKING AND INSURANCE
TERM LIFE QUESTIONNAIRE

PLEASE PROVIDE PREMIUM RATES FOR A $100,000 FACE AMOUNT, ANNUAL, RENEWABLE, CONVERTIBLE TERM LIFE POLICY FOR THE *ELEVENTH* POLICY YEAR. RATES SHOULD INCLUDE EXPENSE CHARGES AND REFLECT THE EXACT PREMIUM AS PAID BY A CONSUMER. DO NOT LIST RATES PER $1,000.

ISSUE AGE	UNDER-WRITING	MALE STANDARD Premium	MALE STANDARD Dividend	FEMALE STANDARD Premium	FEMALE STANDARD Dividend
25					
35					
45					
50					

PLEASE ANSWER BY USING APPROPRIATE LETTER

(A) MEDICAL EXAM _____

(B) QUESTIONNAIRE _____

(C) OTHER, EXPLAIN

PLEASE RETURN TO:

OFFICE OF PUBLIC AFFAIRS

NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE

PO BOX 325

TRENTON, NJ 08625–0325

Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).
Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

SUBCHAPTER 32. VALUATION OF LIFE INSURANCE POLICIES

Authority

N.J.S.A. 17:1–15e and 17B:19–8.

Source and Effective Date

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).

11:4–32.1 Purpose and scope

(a) The purpose of this subchapter is to provide:

1. Tables of select mortality factors and rules for their use;

2. Rules concerning a minimum standard for the valuation of plans with non-level premiums or benefits; and

3. Rules concerning a minimum standard for the valuation of plans with secondary guarantees.

(b) The method for calculating basic reserves defined in this subchapter will constitute the Commissioners' Reserve Valuation Method for policies to which this subchapter is applicable.

(c) This subchapter shall apply to all life insurance policies, with or without nonforfeiture values, issued on or after January 1, 2000, subject to the following exceptions:

1. This subchapter shall not apply to any individual life insurance policy issued on or after January 1, 2000 if the policy is issued in accordance with and as a result of the exercise of a reentry provision contained in the original life insurance policy of the same or greater face amount, issued before January 1, 2000, that guarantees the premium rates of the new policy. This subchapter also shall not apply to subsequent policies issued as a result of the exercise of such a provision, or a derivation of the provision, in the new policy.

2. This subchapter shall not apply to any universal life policy that meets all the following requirements:

i. The secondary guarantee period, if any, is five years or less;

ii. The specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the 1980 CSO valuation tables as defined at N.J.A.C. 11:4–32.2 and the applicable valuation interest rate; and

iii. The initial surrender charge is not less than 100 percent of the first year annualized specified premium for the secondary guarantee period.

3. This subchapter shall not apply to any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

4. This subchapter shall not apply to any variable universal life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

5. This subchapter shall not apply to a group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

GROUP HEALTH (SERVICE CORP.)

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

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

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

INDIVIDUAL CREDIT

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

GROUP CREDIT

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

MORTGAGE GUARANTEE

CODE	COVERAGE TYPE
MG	Mortgage Guarantee

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

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

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

SUBCHAPTER 41. STANDARDS FOR INDIVIDUAL LIFE INSURANCE POLICY FORMS

Authority

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

Source and Effective Date

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

11:4–41.1 Purpose and scope

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

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

11:4–41.2 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11:4–41.3 General standards

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

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

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

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

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

11:4–41.12 Standards for custom design products

(a) Pursuant to (b) below, the Department shall permit the use of a single policy form to provide more than one product where there are alternative plans. The submission shall include specimen issues of the schedule pages and any related tables of values for each alternative plan.

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

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

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

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

4. Other alternative plans that are substantially similar in product design to the primary plan submitted. Determination of substantial similarity shall be within the sole discretion of the Commissioner.

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

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

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

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

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

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

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

7. A policy form may not be issued both with and without a minimum premium period.

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

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

Recodified from N.J.A.C. 11:4–41.15 and amended by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
Rewrote (a); in (b), added 4; and in (c), deleted former 2 and 3, recodified former 4 through 8 as 2 through 6, recodified former 9 as 7 and deleted ", or for minimum premium periods of different durations" at the end, deleted a former 10, and recodified former 11 and 12 as 8 and 9. Former N.J.A.C. 11:4–41.12, Standards for designated life options, repealed.

11:4–41.13 Effect on previously filed forms

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

Amended by R.1997 d.60, effective February 3, 1997.
See: 28 N.J.R. 4563(a), 29 N.J.R. 425(c).
Substituted "December 31, 1996" for "six months following the effective date of these rules".
Recodified from N.J.A.C. 11:4–41.16 by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
Former N.J.A.C. 11:4–41.13, Standards for survivorship forms, recodified to N.J.A.C. 11:4–41.10.

11:4–41.14 (Reserved)

Recodified to N.J.A.C. 11:4–41.11 by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).

11:4–41.15 (Reserved)

Recodified to N.J.A.C. 11:4–41.12 by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).

11:4–41.16 (Reserved)

Recodified to N.J.A.C. 11:4–41.13 by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).

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

Authority

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

Source and Effective Date

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

11:4–42.1 Purpose and scope

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

(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' compensation 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.

(d) Group policies and certificates providing health or blanket insurance that contain provisions relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six months.

1. A subsequent disability resulting from an unrelated cause shall not be a recurrent disability.

(e) Group policies and certificates providing accidental death and dismemberment benefits shall provide that such benefits shall be payable if the loss occurs within a period no less than 90 days from the date of the accident.

1. There shall be no requirement that the covered person be disabled at the time of loss.

2. The form shall state, in effect, that neither termination of the group policy nor termination of the covered person's coverage under the group policy shall prejudice the settlement of any claim for loss where the accident precipitating the loss occurred on or before the date of termination.

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

Authority

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

Source and Effective Date

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

11:4–43.1 Purpose and scope

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

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

11:4–43.2 Definitions

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

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

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

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

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

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

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

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

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

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

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

11:4–43.3 General requirements and prohibitions

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

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

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

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

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

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

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

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

11:4–43.4 Individual immediate annuities

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

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

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

11:4–43.5 Individual deferred annuities

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

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

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

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

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

2. A signature by the purchaser.

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

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

11:4–43.6 Waiver of surrender charges

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

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

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

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

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

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

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

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

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

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

11:4–43.7 Surrender charges for individual deferred annuities

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

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

SUBCHAPTER 44. STANDARDS FOR CONTRACTS ON A VARIABLE BASIS

Authority

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

Source and Effective Date

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

11:4–44.1 Purpose and scope

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

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

11:4–44.2 Definitions

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

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

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

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

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

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

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

11:4–44.3 Standards for variable contracts

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

1. A provision describing the periodic reports;

2. A provision specifying any rights for deferral. Payment of a death benefit in excess of any minimum guaranteed death benefits, of cash values, of partial withdrawals or of partial surrenders dependent upon the valuation of the separate account may be deferred for any period during which the New York Stock Exchange is closed for trading (except for normal holiday closings) or when the Securities and Exchange Commission has determined that a state of emergency exists which may make such payment impractical. Any deferral of a minimum guaranteed death benefit for an individual variable life insurance contract shall comply with N.J.S.A. 17B:25–11; and

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

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

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

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

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

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

11:4–44.4 Prohibited provisions

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

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

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

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

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

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

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

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

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

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

SUBCHAPTER 45. PERIODIC REPORTS

Authority

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

Source and Effective Date

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

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

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

New Rule, R.1998 d.337, effective July 6, 1998.
See: 30 N.J.R. 275(a), 30 N.J.R. 2492(a).
Former N.J.A.C. 11:4–45.7, Penalties, recodified to N.J.A.C. 11:4–45.8.

11:4–45.8 Penalties

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

Recodified from N.J.A.C. 11:4–45.7 and amended by R.1998 d.337, effective July 6, 1998.
See: 30 N.J.R. 275(a), 30 N.J.R. 2492(a).
Substituted a reference to variable life insurance forms for a reference to individual life insurance forms and inserted a reference to forms for which illustrations are used pursuant to N.J.A.C. 11:4–52.
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 46. SYNTHETIC GUARANTEED INVESTMENT CONTRACT FORMS

Authority

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

Source and Effective Date

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

11:4–46.1 Purpose and scope

(a) The purpose of this subchapter is to implement P.L. 1995, c.73 (the Life and Health Insurance and Health Maintenance Organization Form Approval Reform Act) by setting forth the terms and conditions under which life insurance companies may issue synthetic guaranteed investment contracts, the essential operational features of the segregated portfolio of assets required to issue such contracts and the reserve requirements for such contracts.

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

11:4–46.2 Definitions

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

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

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

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

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

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

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

11:4–46.5 Contract requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11. A waiver provision as follows:

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

11:4–46.6 General requirements

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

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

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

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

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

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

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

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

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

11:4–46.7 Reserves

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

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

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

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

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

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

11:4–46.8 Severability

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

SUBCHAPTER 47. ACTUARIAL REQUIREMENTS FOR FLEXIBLE–FACTOR POLICY FORMS

Authority

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

Source and Effective Date

R.1996 d.83, effective February 5, 1996.
See: 27 N.J.R. 3750(a), 28 N.J.R. 1215(a).

11:4–47.1 Purpose and scope

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

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

11:4–47.2 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11:4–47.6 Recordkeeping

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

11:4–47.7 Penalties

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

APPENDIX

EXHIBIT 1

DETECTION AND AVOIDANCE OF DISCONTINUITIES IN LIFE INSURANCE POLICIES

Detecting Possible Manipulation: The Mechanical Approach

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

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

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

2. The test is applied to the sum of the squares of the second backward differences in yearly prices. This measure is obtained as follows: First, the differences between successive changes in yearly prices are calculated. These "second differences" are then squared to avoid the offsetting effect of positive and negative values. Finally, the squared second differences are added for policy years 8–23. Because the test omits from the calculation yearly prices prior to year 6, it will not detect irregularities in yearly prices during the first five policy years. The use of the mechanical approach in early policy years is burdened by variations in expense amortization and in early year cash surrender values. It was the judgment of the committee that incorporation of yearly prices beyond policy year 23 is currently unnecessary.

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

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

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

Example 1

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

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

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

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

Policy Year	(1) Yearly Price	(2) Second Difference in Yearly Price	(3) Second Difference Squared
22	10.98	–16.96	287.6416
23	10.93	.02	.0004
24	10.91	.03	NA
25	10.91	.02	NA
26	10.94	.03	NA
27	11.00	.03	NA
28	11.06	.00	NA
29	11.15	.03	NA
30	11.27	.03	NA

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

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

–16.63 — (–5.84–10.47) – (10.47–10.15)
— –16.31–.32
— –16.63

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

The second example is a guaranteed cost policy issued to a male age 25. It has a six percent policy loan rate. The calculation is made on a per $1,000 basis.

Example 2

Policy Year	Guaranteed Cash Value	Illustrated Annual Dividend	Illustrated Terminal Dividend	Premium
1	0.0	0.0	0.0	11.34
2	0.0	0.0	0.0	11.34
3	0.02	0.0	0.0	11.34
4	9.77	0.0	0.0	11.34
5	19.84	0.0	0.0	11.34
6	30.23	0.0	0.0	11.34
7	40.95	0.0	0.0	11.34
8	52.01	0.0	0.0	11.34
9	63.41	0.0	0.0	11.34
10	75.17	0.0	0.0	11.34
11	87.27	0.0	0.0	11.34
12	99.71	0.0	0.0	11.34
13	112.48	0.0	0.0	11.34
14	125.54	0.0	0.0	11.34
15	138.90	0.0	0.0	11.34
16	152.53	0.0	0.0	11.34
17	166.43	0.0	0.0	11.34
18	180.59	0.0	0.0	11.34
19	195.03	0.0	0.0	11.34
20	224.12	0.0	0.0	11.34
21	230.80	0.0	0.0	11.34
22	253.71	0.0	0.0	11.34
23	268.85	0.0	0.0	11.34
24	284.20	0.0	0.0	11.34
25	299.73	0.0	0.0	11.34
26	315.43	0.0	0.0	11.34
27	331.29	0.0	0.0	11.34
28	347.29	0.0	0.0	11.34
29	363.43	0.0	0.0	11.34
30	379.67	0.0	0.0	11.34

Policy Year	(1) Yearly Price	(2) Second Difference in Yearly Price	(3) Second Difference Squared
1	11.34	—	NA
2	11.34	—	NA
3	11.32	–.02	NA
4	2.06	–9.24	NA
5	2.21	9.41	NA
6	2.39	.03	NA
7	2.57	.00	NA
8	2.76	.01	.0001
9	2.96	.01	.0001
10	3.16	.00	.0000
11	3.40	.04	.0016
12	3.65	.01	.0001
13	3.93	.03	.0009
14	4.26	.05	.0025
15	4.59	.00	.0000
16	4.97	.05	.0025
17	5.37	.02	.0004
18	5.78	.01	.0001
19	6.19	.00	.0000
20	–7.08	–17.68	187.1424
21	15.65	36.00	1,296.0000
22	.51	–37.87	1,434.1369
23	9.00	23.63	558.3769
24	9.52	–7.97	NA
25	10.08	.04	NA
26	10.66	.02	NA
27	11.26	.02	NA
28	11.88	.03	NA
29	12.51	.01	NA
30	13.18	.04	NA

The sum of the squared second differences between years 8 and 23 for example two is 3476. It exceeds by 3176 the test limit for issue age 25 of 300. A company actuary would be required to justify the abrupt discontinuities in yearly prices between years 20 and 23. These discontinuities are attributable to the unusual cash surrender value progression during these years.

SUBCHAPTER 48. UNFAIR DISCRIMINATION

Authority

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

Source and Effective Date

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

11:4–48.1 Purpose and scope

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

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

11:4–48.2 Definitions

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

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

"Commissioner" means the Commissioner of the New Jersey Department of 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.

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

1. A retroactive refund of past mortality or expense charges at some duration;

2. A retroactive increase in past interest credits at some duration;

3. A percentage increase in the accumulation amount at some duration; and

4. Factor enhancement bonuses which provide for the crediting of a higher interest rate or the charging of a lower expense or mortality charge commencing at some duration.

"Tiered factors" means accumulation account factors, such as interest rates, cost of insurance or mortality charges, and expense charges, which vary by a policy amount, such as accumulation account value, cash surrender value, face value, or net amount at risk, or which differ for various components or tiers of a policy amount. Tiered factors reflect economies of scale or other economies so that credits will increase with size and charges will decrease with size. Tiered factors do not include factors which vary by policy duration.

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

11:4–48.3 General requirements

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

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

11:4–48.4 Persistency bonus

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

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

2. The insurer shall include in its submission to the Department an actuarial certification that the nonguaranteed bonus does not unfairly discriminate between persons who lapse or surrender their policies before the

policy year of crediting the bonus and those who continue their policy in force, as prohibited by N.J.S.A. 17B:30–12(c). The submission shall include an explanation of the reason for and source of the bonus which focuses on the completion of amortization expenses and the release of interest margins. Higher investment yields on long term assets or hypothetically better mortality of persisting policyholders will not provide sufficient justification for a bonus.

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

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

Amended by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
Rewrote (a)2.

11:4–48.5 Conversion credits

The Department shall approve life insurance policy forms that provide conversion credits pursuant to N.J.S.A. 17B:30–14e.

Recodified from N.J.A.C. 11:4–48.6 and amended by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
Rewrote (a). Former N.J.A.C. 11:4–48.5, Tiered factors, repealed.

11:4–48.6 Non–smoker only coverage

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

Recodified from N.J.A.C. 11:4–48.7 by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
Former N.J.A.C. 11:4–48.6, Conversion credits, recodified to N.J.A.C 11:4–48.5.

11:4–48.7 Policy benefits determined by ownership

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

Recodified from N.J.A.C. 11:4–48.8 by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
Former N.J.A.C. 11:4–48.7, Non-smoker only coverage, recodified to N.J.A.C 11:4–48.6.

11:4–48.8 Forgiveness of surrender charge

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

Recodified from N.J.A.C. 11:4–48.9 by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
Former N.J.A.C. 11:4–48.8, Policy benefits determined by ownership, recodified to N.J.A.C 11:4–48.7.

11:4–48.9 Discounts and reductions in premium in individual health insurance

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

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

2. The reduction in premium is based on additional requirements applied to the discounts allowed by N.J.S.A. 17B:30–14d and 17B:30–14e. For example, list bill discounts with minimum premium requirements, or list bill discounts which vary based on level of participation are considered a separate class subject to the requirements of this section. Each reduction in premium shall be considered a separate class.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recodified from N.J.A.C. 11:4–48.10 by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).
Former N.J.A.C. 11:4–48.9, Forgiveness of surrender charge, recodified to N.J.A.C 11:4–48.8.

11:4–48.10 (Reserved)

Recodified to N.J.A.C. 11:4–48.9 by R.2000 d.130, effective March 20, 2000.
See: 31 N.J.R. 3910(a), 32 N.J.R. 1024(a).

SUBCHAPTER 49. MANDATED DIABETES BENEFITS

Authority

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

Source and Effective Date

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

11:4–49.1 Purpose and scope

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

(b) This subchapter shall apply to all policies and contracts providing hospital or medical expense benefits that are delivered, issued, executed or renewed in this State as follows: all hospital service corporation contracts issued pursuant to N.J.S.A. 17:48–1 et seq.; all medical service corporation contracts issued pursuant to N.J.S.A. 17:48A–1 et seq.; all health service corporation contracts issued pursuant to N.J.S.A. 17:48E–1 et seq.; all health insurance policies issued pursuant to N.J.S.A. 17B:26–1 et seq., and 17B:27–26 et seq.; and all health maintenance organization (HMO) contracts issued pursuant to N.J.S.A. 26:2J–1 et seq.

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

11:4–49.2 Definitions

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

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

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

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

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

11:4–49.3 Benefits

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

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

i. Blood glucose monitors and blood glucose monitors for the legally blind;

ii. Test strips for glucose monitors and visual reading and urine testing strips;

iii. Insulin;

iv. Injection aids;

v. Cartridges for the legally blind;

vi. Syringes;

vii. Insulin pumps and appurtenances thereto;

viii. Insulin infusion devices; and

ix. Oral agents for controlling blood sugar; and

2. All expenses incurred for diabetes self-management education, including information on proper diet. "Diabetes self-management education" as used in this paragraph means education to ensure that a person with diabetes is educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet.

i. All self-management and diet education shall be provided by a dietitian registered by a nationally recognized professional association of dietitians, a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators, or a registered pharmacist in the State qualified with regard to management education for diabetes by any institution recognized by the Board of Pharmacy of the State of New Jersey.

ii. Benefits for self-management education related to diet shall be limited to visits medically necessary upon the diagnosis of diabetes, upon diagnosis by a State licensed physician or nurse practitioner/clinical nurse specialist of a significant change in the subscriber's or other covered person's symptoms or conditions which necessitate changes in that person's self-management, and upon determination of a State licensed physician or nurse practitioner/clinical nurse specialist that re-education or refresher education is necessary.

(b) The benefits required to be provided pursuant to this subchapter shall be provided to the same extent as benefits are provided for services and supplies for any other sickness under the policy or contract. There shall be no separate deductible, coinsurance or maximum limit applicable to the services and supplies set forth in (a) above.

11:4–49.4 Payment of benefits under multiple coverage plans

All group health insurance policies or contracts providing hospital or medical expense benefits, except for policies or contracts providing prescription drug benefits, may provide that the benefits required to be provided pursuant to this subchapter are excluded if the benefits are included under another group health insurance policy or contract issued to the same policyholder or contractholder.

SUBCHAPTER 50. REIMBURSEMENT OF INMATE HEALTH CARE COSTS

Authority

N.J.S.A. 17:1–8.1, 17:1–15e, and 30:7E–3f.

Source and Effective Date

R.1997 d.513, effective December 1, 1997.
See: 29 N.J.R. 2232(a), 29 N.J.R. 5066(a).

11:4–50.1 Purpose and scope

(a) In conformance with N.J.S.A. 30:7E–1 et seq., the purpose of this subchapter is to establish rules for the reimbursement of costs incurred in the provision of medical care, hospitalization, surgery, dental care and vision care to inmates that are covered by a health coverage plan and are incarcerated or detained in a State or county institution.

(b) These rules shall not apply to those self-funded health care plans which are subject to the Employee Retirement Income Security Act of 1974 (ERISA).

(c) Pursuant to P.L. 1997, c.216, section 3, the Administrative Office of the Courts, in accordance with these rules, shall be permitted to file claims for reimbursement, subject to the terms of coverage, for the psychological evaluation of convicted persons.

11:4–50.2 Definitions

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

"Confinement" means incarceration, detention or commitment to any institution.

"Correctional medical services subcontractor" and "correctional medical services health care provider" are those private associations, agencies or companies hired or contracted by the State or counties to provide medical care, services, or products to inmates.

"Covered person" means any person who is covered by a health coverage plan but not as an enrollee.

"Enrollee" means a person who receives or subscribes to a policy, contract, certificate, evidence of coverage or other proof of coverage from the health coverage plan that covers that person for health benefits and expenses.

"Health coverage plan" means any hospital or medical expense insurance policy; health, hospital or medical service corporation contract or certificate; or health maintenance organization ("HMO") subscriber contract or evidence of coverage; dental plan organization, contract or certificate ("DPO"); dental service corporation, contract or certificate ("DSC"); or vision plan.

"Inmate" means any person sentenced to confinement or held in pretrial detention in an institution.

"Institution" refers to any State correctional facility, State contracted half-way house, county jail, county correctional or detention facility.

11:4–50.3 Liability for medical care

Inmates are liable for the cost of any medical care, surgery, medical service, nursing care, prescription drugs,

nonprescription drugs, durable medical equipment, hospitalization, therapy treatment, dental care, vision care provided to them while in confinement.

11:4–50.4 Amount of inmate liability

Pursuant to N.J.S.A. 30:7E–2, the amount of inmate liability for medical care shall be the usual, customary and reasonable charges incurred for the inmate's medical care as determined by the State and county treasurers in accordance with the guidelines promulgated by the Commissioner of Corrections or the County Adjuster.

11:4–50.5 Health coverage plans

(a) In accordance with N.J.S.A. 30:7E–3, State and County Treasurers shall file a claim for reimbursement of the value of the usual, customary and reasonable charges incurred for an inmate's medical care upon any health coverage plan providing benefits to an inmate as an enrollee or as a covered person.

(b) Subject to the terms of coverage of the policy or plan, health coverage plans shall be required to reimburse the State or county for costs expended in providing medical care to any inmate covered under the plan.

(c) Notwithstanding the provisions of N.J.A.C. 8:38–1.2 (definition of "emergency"), it shall be presumed that inmates are in need of emergency medical care and are not located in a place where it can be rendered by any network health care provider. The institutional medical health care provider is deemed to be the inmate's only available source of medical care.

(d) Where practicable, the institutional health care provider shall confer with the health coverage plan to preserve the right of said plans to negotiate fees for testing, specialists and hospitalization.

11:4–50.6 Filing of claims for reimbursement

(a) Where the inmate is an enrollee, he or she shall provide a signed and completed assignment of benefits form in favor of the treasurer of the State or county institution, a claims form and a medical release. These forms shall be obtained from the inmate's plan. The assignment of benefit form shall designate the State or County Treasurer as the assignee for the reimbursement of benefits. Such forms shall be used by the institution to process claims for reimbursement.

(b) Where the inmate is a covered person under a policy or plan of health insurance, the enrollee shall complete the assignment of benefits form designating the State or county treasurer of the institution as the recipient for the reimbursement of benefits. Thereafter, the inmate shall execute all claims and medical release forms.

(c) The forms and claims filing procedures established by the health care plan shall, in so far as practicable, be followed by the institution to facilitate the reimbursement of benefits. All health care plans shall cooperate in the expeditious processing of claims for reimbursement received from institutions rendering medical services, care and products to inmates.

(d) All health care plans shall be obligated, notwithstanding their approved policy terms and procedures, to accept any assignment of benefits executed by or on behalf of an inmate for medical care and services provided to the inmate while institutionalized.

(e) All reimbursement payments for medical care provided to an inmate shall be made payable to the State or county treasurer of the institution designated on the assignment of benefits form.

11:4–50.7 Coordination of benefits

(a) The determination of primary coverage responsibility shall be governed by N.J.A.C. 11:4–28 to determine the priority of reimbursement in the event of multiple coverages of an inmate.

(b) For the purpose of the coordination of benefits, the medical services provided by the institution, the correctional medical service subcontractor and the correctional medical service health care provider shall not be considered a "plan" as defined in N.J.A.C. 11:4–28.

11:4–50.8 Policy forms

Health coverage plans shall not contain any provision which would limit or restrict the ability of the State or county treasurers to seek reimbursement for the cost of medical services provided to inmates under N.J.S.A. 30:7E–1 et seq.

SUBCHAPTER 51. (RESERVED)

SUBCHAPTER 52. LIFE INSURANCE ILLUSTRATIONS

Authority

N.J.S.A. 17:1–8.1, 17:1–15e, 17B:17–17 et seq. and 17B–30–1 et seq.

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