

**CHAPTER 4**  
**ACTUARIAL SERVICES**

**Authority**

N.J.S.A. 17:1-8.1 and 17:1-15(e).

**Source and Effective Date**

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

**Chapter Expiration Date**

Chapter 4, Actuarial Services, expires on March 14, 2011.

**Chapter Historical Note**

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

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

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

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

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

Subchapter 13, Group Student Health Insurance, was adopted as R.1977 d.309, effective August 22, 1977. See: 9 N.J.R. 343(c), 9 N.J.R. 438(d).

Subchapter 14, Home Health Care Insurance Coverage, was adopted as R.1977 d.476, effective December 15, 1977. See: 9 N.J.R. 479(f), 10 N.J.R. 16(d).

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

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

Subchapter 16, Minimum Standards for Individual Health Insurance, Subchapter 17, Health Insurance Solicitation, and Subchapter 18, Individual Health Insurance Rate Filings, were adopted as new rules by R.1980 d.176, effective April 21, 1980. See: 11 N.J.R. 348(a), 12 N.J.R. 342(c).

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

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

Subchapter 2, Replacement of Life Insurance Policy, was repealed and Subchapter 2, Replacement of Life Insurance Policy, was adopted as new rules by R.1982 d.16, effective February 1, 1982, operative June 1, 1982.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

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

Subchapter 22, Individual Life Insurance: Use of Gender Blended Mortality Tables, was adopted as R.1984 d.478, effective November 5, 1984. See: 16 N.J.R. 1452(a), 16 N.J.R. 3040(a).

Pursuant to Executive Order No. 66(1978), Subchapter 6, Reserve Standards for Individual Health Insurance Policies, was readopted as R.1984 d.512, effective November 5, 1984. See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

Subchapter 23, Medicare Supplement Policies and Contracts, was adopted as R.1985 d.70, effective February 19, 1985, operative June 19, 1985. See: 16 N.J.R. 2945(a), 17 N.J.R. 460(a).

Pursuant to Executive Order No. 66(1978), Subchapter 20, Blindness; Partial Blindness or Other Physical or Mental Impairments; Unfair Discrimination, was readopted as R.1985 d.161, effective April 1, 1985. See: 17 N.J.R. 168(a), 17 N.J.R. 820(a).

Pursuant to Executive Order No. 66(1978), Subchapter 16, Minimum Standards for Individual Health Insurance, Subchapter 17, Health Insurance Solicitation, and Subchapter 18, Individual Health Insurance Rate Filings were readopted as R.1985 d.221, effective April 15, 1985. See: 17 N.J.R. 554(a), 17 N.J.R. 1129(a).

Subchapter 21 was readopted as R.1985 d.325, effective June 3, 1985. See: 17 N.J.R. 891(a), 17 N.J.R. 1660(a).

Subchapter 24, Smoker and Nonsmoker Mortality Tables, was adopted as R.1985 d.617, effective December 2, 1985. See: 17 N.J.R. 2348(a), 17 N.J.R. 2907(a).

Subchapter 26, Annuity Mortality Tables, was adopted as R.1985 d.616, effective December 2, 1985. See: 17 N.J.R. 2349(a), 17 N.J.R. 290(a).

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

Subchapter 19, Optional Coverage for Pregnancy and Childbirth Benefits, was adopted as R.1988 d.455, effective September 19, 1988. See: 20 N.J.R. 43(a), 20 N.J.R. 2377(c).

Subchapter 28, Group Coordination of Benefits, was adopted as new rules by R.1988 d.499, effective October 17, 1988. See: 20 N.J.R. 1773(b), 20 N.J.R. 2581(a).

Subchapter 29, Homeowners Comparison Survey, was adopted as R.1989 d.50, effective January 17, 1989. See: 20 N.J.R. 2181(a), 21 N.J.R. 164(a).

Subchapter 31, Term Life Insurance Comparison Survey, was adopted as R.1989 d.122, effective February 21, 1989. See: 20 N.J.R. 2990(a), 21 N.J.R. 566(a).

Subchapter 32, Health Service Corporation Notice of Increased Rates, was adopted as R.1989 d.522, effective October 2, 1989. See: 21 N.J.R. 973(b), 21 N.J.R. 3173(c).

Subchapter 33, Excess Interest Reserve Adjustment, was adopted as R.1989 d.523, effective October 2, 1989. See: 21 N.J.R. 1308(a), 21 N.J.R. 3175(c).

Subchapter 34, Long-Term Care Insurance, was adopted as R.1989 d.571, effective November 6, 1989. See: 21 N.J.R. 1964(a), 21 N.J.R. 3465(a).

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

Pursuant to Executive Order No. 66(1978), Chapter 4 was readopted as R.1991 d.3, effective November 30, 1990, Subchapter 1, Contracts on a Variable Basis, was repealed by R.1991 d.3, effective January 7, 1991. See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).

Subchapter 35, Annual Medicare Supplement Policy Survey, was adopted as R.1991 d.122, effective March 4, 1991. See: 22 N.J.R. 1226(b), 23 N.J.R. 698(a).

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

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

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

Subchapter 9, Personal Lines Insurance: Prospective Loss Costs Filing Procedures, was adopted as R.1995 d.406, effective August 7, 1995. See: 27 N.J.R. 1356(b), 27 N.J.R. 2931(a).

Subchapter 30, Accelerated Death Benefits, was adopted as R.1995 d.521, effective September 18, 1995. See: 27 N.J.R. 2046(a), 27 N.J.R. 3613(c).

Subchapter 40, Life/Health/Annuity Forms, was adopted as R.1995 d.569, effective November 6, 1995. See: 27 N.J.R. 2857(a), 27 N.J.R. 2867(a), 27 N.J.R. 4317(a).

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

Pursuant to Executive Order No. 66(1978), Chapter 4, Actuarial Services, was readopted as R.1996 d.4, effective November 30, 1995, and Subchapter 5, Amendment to Instructions to Life and Accident and Health Annual Statement Blank, Subchapter 10, Expense Experience, Subchapter 32, Health Service Corporation Notice of Increased Rates, Subchapter 35, Annual Medicare Supplement Policy Survey, and Exhibits A and B of the Appendix to Subchapters 16 and 23 were repealed by R.1996 d.4, effective January 2, 1996. See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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SUBCHAPTER 40. LIFE/HEALTH/ANNUITY  
FORMS

**11:4-40.1 Purpose and scope**

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

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

**11:4-40.2 Definitions**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"State" means the State of New Jersey.

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

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

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

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

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

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

(c) Annuity contracts, other than individual contracts and synthetic guaranteed investment contracts, are exempt from compliance with this subchapter.

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

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

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

Added (c).

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

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

Added (d).

#### 11:4-40.4 General requirements

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

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

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

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

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

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

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

- i. The date appearing on a clear, legible postmark affixed by the United States Postal Service;
- ii. The legible date of receipt from the sender appearing on the transmission documents of a private delivery service; or
- iii. In the absence of either (a)4i or ii above, the actual date of receipt by the Department.

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

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

**11:4-41.8 Standards for field issue contracts**

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

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

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

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

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

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

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

**11:4-41.9 Standards for other insured coverage**

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

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

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

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

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

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

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

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

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

Recodified from N.J.A.C. 11:4-41.11 by R.2000 d.130, effective March 20, 2000.

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

Former N.J.A.C. 11:4-41.9, Standards for extension or cancellation of maturity dates, repealed.

**11:4-41.10 Standards for survivorship forms**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) The form shall provide for reinstatement pursuant to N.J.A.C. 11:4-41.3(b)8. The insurer shall only require evidence of insurability on any insured alive on the date of default.

Recodified from N.J.A.C. 11:4-41.13 by R.2000 d.130, effective March 20, 2000.

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

Former N.J.A.C. 11:4-41.10, Standards for policy split options, repealed.

Amended by R.2001 d.100, effective March 19, 2001.

See: 32 N.J.R. 4045(a), 33 N.J.R. 1006(a).

Rewrote (c)4.

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

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

Added (f).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Medicare.

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

## SUBCHAPTER 43. INDIVIDUAL ANNUITY CONTRACT FORM STANDARDS

### 11:4-43.1 Purpose and scope

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

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

### 11:4-43.2 Definitions

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

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

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

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

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

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

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

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

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

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

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

### 11:4-43.3 General requirements and prohibitions

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

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

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

1. If a form guarantees an interest rate of less than three percent during the accumulation phase, the insurer shall include with the submission a demonstration that policy values and benefits are not less than the minimum nonforfeiture amounts specified in N.J.S.A. 17B:25-20g.
2. If a form offers varying interest rate guarantee periods, specimen specification pages shall be submitted for each of the various guarantee periods.
3. The same contract form shall not be issued as both an immediate and a deferred annuity.
4. The form shall contain a provision describing any method for adjusting benefits and values on the basis of misstatement of age or sex. Interest may be applied in determining overpayments and underpayments at a rate specified in the form. The same specified rate shall apply to overpayments and underpayments.

(d) An insurer shall 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.

(f) The form may contain language that permits the insurer unilaterally to amend or modify the form to satisfy any applicable law. However, the owner shall be permitted to refuse any such change unless noncompliance would cause the contract to be null and void or fail to comply with New Jersey or Federal law.

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

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

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

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

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

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

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

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

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

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

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

Added (h).

#### 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.

APPENDIX B

Self-Funded MEWA Loss Ratio Report Form  
Small Employer Business

Reporting Year (Year in which this report was prepared) \_\_\_\_\_  
For Preceding Calendar Year Ending December 31, \_\_\_\_\_

Name of MEWA: \_\_\_\_\_  
Address of MEWA: \_\_\_\_\_

- 1. Premiums \_\_\_\_\_
- 2. Claims (a. + b.-c. + d.-e.) \_\_\_\_\_
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
  - d. \_\_\_\_\_
  - e. \_\_\_\_\_

- 3. Loss Ratio (2./1.) \_\_\_\_\_
- 4. Dividends (.75 x 1.)- 2. \_\_\_\_\_

Signature of Preparer \_\_\_\_\_ Date \_\_\_\_\_  
Name of Preparer Title \_\_\_\_\_ Title \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone Number \_\_\_\_\_

- 1. Premiums are total earned premiums for small employer business, before any dividends or credits applicable to prior year's Loss Ratio Reports.
- 2. Claims for small employer business are equal to:
  - a. claims paid in the preceding calendar year regardless of year incurred; plus
  - b. claims paid from January 1 to June 30 of the reporting year for claims incurred prior to January 1 of the reporting year; less
  - c. claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year (as reported in the preceding year's Loss Ratio Report); plus
  - d. a residual reserve equal to 3.3 percent of a. + b.-c.; less
  - e. a residual reserve (as reported in the preceding year's Loss Ratio Report).
- 3. Loss Ratio is the quotient, to the nearest .1 percent, of the Claims dividend by the Premiums (2. divided by 1.)
- 4. Dividends are 0 if the amount on Line 3 is 75.0% or greater. Otherwise, dividends are equal to (75% of Line 1.) minus Line 2.

SUBCHAPTER 57. MANDATED BENEFITS FOR  
BIOLOGICALLY-BASED MENTAL ILLNESS

**11:4-57.1 Purpose and scope**

(a) The purpose of this subchapter is to implement P.L. 1999, c.106 by specifying that certain exclusions may not be applied to treatment of biologically-based mental illness, and that benefit limits in health insurance policies and health maintenance organization contracts may not be applied to deny medically necessary benefits or services for the treatment of biologically-based mental illness when those benefit limits are not applied in the same manner to treatments for other illnesses.

(b) This subchapter shall apply to all policies and contracts providing hospital or medical services or benefits that are delivered, issued, executed or renewed in this State in the individual, small group and large group markets 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., 17B:27-26 et seq., 17B:27A-2 et seq. and 17B:27A-17 et seq.; and all health maintenance organization contracts issued pursuant to N.J.S.A. 26:2J-1 et seq.

**11:4-57.2 Definitions**

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

“Benefit limit” means any restriction, condition, or limitation (including, but not limited to, visit limits, dollar limits and preauthorization requirements) applied to the provision of health care services or benefits in a health insurance policy or health maintenance organization contract.

“Biologically-based mental illness” (BBMI) means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including, but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

“Carrier” means any insurer authorized to sell health insurance pursuant to Title 17B of the New Jersey Statutes; a health, hospital or medical service corporation; or a health maintenance organization.

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

“Exclusion” means a provision in a policy or contract that limits the scope of coverage by specifying causes and conditions for which benefits are not provided.

“Form” means any individual or group health insurance policy, health maintenance organization contract, any rider or endorsement for use with such policy or contract, certificates and evidence of coverage forms.

“Preauthorization” means a carrier’s authorization, using paper or electronic means, for specified services or supplies that is given prior to the date the services or supplies are provided.

### 11:4-57.3 Exclusions and benefit limits

(a) Notwithstanding the applicability of such exclusions to persons with physical illness, carriers shall not apply any exclusion in a health insurance policy or health maintenance organization contract to deny benefits for services or supplies that are medically necessary for the treatment of covered persons with biologically-based mental illness, so long as such services or supplies are not experimental or investigational. This proscription shall include but not be limited to:

1. Exclusions for the treatment of chronic conditions;
2. Exclusions for physical, speech and occupational therapy that is non-restorative (that is, that does not restore previously possessed function, skill or ability);
3. Exclusions for services rendered after a fixed period of time has elapsed from an injury, procedure or the onset of illness;

4. Exclusions for the treatment of developmental disorders or developmental delay;
5. Exclusions for therapy on a long-term basis;
6. Exclusions for the treatment of behavioral problems; and
7. Exclusions for the treatment of learning disabilities.

(b) Subject to (a) above, carriers may apply benefit limits, including preauthorization requirements, to treatment of biologically-based mental illness only if those benefit limits, including preauthorization requirements, are applicable to treatments of physical illnesses. Visit limits and preauthorization requirements may be applied only to the extent stated in (b)1 and 2 below.

#### 1. Visit limits:

i. Visit limits may be applied to therapy for the treatment of biologically-based mental illness if the same visit limits are applied to therapy for the treatment of physical illness. For example, a limit of 30 speech therapy visits per year is permitted for speech therapy that is required to treat a biologically-based mental illness (such as autism or pervasive developmental disorder), so long as the limit also applies to speech therapy that is required to treat a physical illness (such as stroke).

#### 2. Preauthorization requirements:

i. Preauthorization of all services to treat biologically-based mental illness (that is, blanket preauthorization) is not permitted.

ii. Preauthorization of particular services for the treatment of biologically-based mental illness is permitted only if preauthorization is required for the same or similar services when provided to treat physical illness. For example, a carrier may require preauthorization of partial day hospitalization for the treatment of biologically based mental illness if it also requires preauthorization of intensive outpatient treatments for physical illness such as outpatient surgery, chemotherapy or radiation therapy.

### 11:4-57.4 Effect on previously filed forms

Forms that have been filed by the Commissioner containing provisions not in compliance with this subchapter shall be deemed withdrawn as of July 1, 2005.